phexxi™
(lactic acid, citric acid, and potassium bitartrate) Vaginal Gel 1.8%, 1%, 0.4%

KnippeRx™
Specialty Pharmacy Services

Phexxi™ Enrollment Form

Phone: (877) 452-1061 Fax: (833) 626-0710
Email: PhexxiSupport@KnippeRx.com

Deliver to: ☐ Patient ☐ Prescriber ☐ Other:_____ ☐ Hold until notified Anticipated Start Date: _____

PATIENT INFORMATION

Last Name:_____ First Name:_____ Mobile ( )____-_____ Alt ( )____-_____

Date of Birth:___/___/____ Home Address:_____

Patient Preferred Language:_____ _____

Guardian/Caregiver:_____ City:_____ State:____ Zip:_____

INSURANCE INFORMATION

Pharmacy Insurance:_____ Phone ( )____-_____

BIN:_____ PCN:_____ Group ID:_____ Policy #:_____ Medicare/Medicaid:_____

PRESCRIBER INFORMATION

Prescriber Name:_____ License#:_____NPI:_____ DEA:_____

MD◯DO◯NP◯PA◯Practice:_____ Phone ( )____-_____ Fax ( )____-_____

Address:_____ Office Contact:_____ Phone ( )____-_____ ext____

_____ Office hours:_____

City:_____ State:____ Zip:_____

DIAGNOSIS AND CLINICAL INFORMATION

ICD-10 Diagnosis Code:_____

Clinical Information:_____

Additional Information:_____

Allergies:_____

PRESCRIBING INFORMATION

Medication: Phexxi ™ 1.8-1-0.4% vaginal gel Other current medications:_____

Directions: Insert 1 applicator full intravaginally up to 1 hour prior to vaginal intercourse. _____

Qty:_____ Refills:_____ _____

Prescriber Authorization (No Stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date: _____

I authorize KnippeRx to act on behalf of myself and my patient to initiate any de minimis authorization process from health plans including the submission of any necessary forms to such health plans.

Fax form to 833-626-0710 SureScripts enabled provider
KnippeRx Pharmacy
NABP: 1568560 NPI: 1285159152

Click here or go to phexxi.com for Full Prescribing Information, including BOXED WARNING regarding Cystitis and Pyelonephritis in certain situations.