Addyi Enrollment Form

KnippeRx™
Specialty Pharmacy Services
Phone: (877) 809-3141
Fax: (833) 261-7585
Email: AddyiSupport@KnippeRx.com

Deliver to: ☐ Patient ☐ Prescriber ☐ Other:_____ ☐ Hold until notified by prescriber

Anticipated Start Date: ____/____/_____

PATIENT INFORMATION

Last Name:_____ First Name:_____

Date of Birth:_____/_____/_____ ___S.S. #:_____-____-_____

Patient Preferred Language: _____

Guardian / Caregiver: _____

Mobile: ( ) _____ - _____ Alt: ( ) _____ - _____

Home Address:_____

_____

City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Medical Insurance:_____Phone: _____

Subscriber Name: _____

Policy #:_____ Group #: _____

Pharmacy Insurance:_____ Phone #:_____

Policy #:_____ BIN:_____ PCN:_____

Group ID #:_____ Medicare / Medicaid:_____

PRESCRIBER INFORMATION

Prescriber Name: _____

MD DO NP PA Practice:_____

Address: _____

City:_____ State:_____ ZIP: _____

License #:_____ NPI:_____ DEA:_____

Phone:_____ Fax:_____

Office Contact:_____ Phone: _____

DIAGNOSIS AND CLINICAL INFORMATION

ICD - 10 Diagnosis Code: ☐ F52.0 ☐ Other:_____

Clinical information:_____

_____

Allergies: _____

PRESCRIPTION INFORMATION

Medication: Addyi® 100mg Tablets

Directions: Take 1 tablet by mouth at bedtime. Avoid alcohol.

Qty:_____ Refills:_____

Other current medications: _____

_____

_____

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

Prescriber Signature _____ Date:____/____/_____

PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.

Fax Form to: (833) 261-7585 SureScripts enabled provider

KnippeRx Pharmacy

NABP: 1568560 NPI: 1285159152