CurAccess PATIENT SUPPORT PROGRAM ⊕ KnippeRx™

PRESCRIPTION ORDER FORM
PLEASE FAX THIS FORM TO KNIPPERX PHARMACY AT (833) 289-1711

TREATMENT (check all that apply)

CurAccess Product	Strength	Qty	Refills
❑ **ONZETRA® Xsail® (sumatriptan nasal powder)** 2 nosepieces (1 per nostril) at onset of migraine, may repeat dose after 2 hours prn; Max 2 doses/day **Notes** _____	❑ **22 mg**	❑ **8 doses (16 nosepieces)** ❑ **16 doses (32 nosepieces)** ❑ **24 doses (48 nosepieces)**	❑ **6** ❑ **12** ❑ **Other** _____
❑ **TREXIMET® (sumatriptan/naproxen sodium) Tablets** 1 tablet by mouth at onset of migraine may repeat in 2 hours if needed; Max 2 tablets/day **Notes** _____	❑ **85/500 mg**	❑ **9ct** ❑ **18ct** ❑ **27ct**	❑ **6** ❑ **12** ❑ **Other** _____
❑ **SILENOR® (doxepin) Tablets** 1 tablet by mouth within 30 minutes of bedtime **Notes** _____	❑ **3 mg** ❑ **6 mg**	❑ **30ct** ❑ **60ct** ❑ **90ct**	❑ **6** ❑ **12** ❑ **Other** _____
❑ **CONTRAVE® (naltrexone HCl/bupropion HCl) Extended-Release Tablets** Week 1: AM 1 Tablet Week 2: AM 1 Tablet/PM 1 Tablet Week 3: AM 2 Tablets/PM 1 Tablet Week 4 and beyond: AM 2 Tablets/PM 2 Tablets **Notes** _____	❑ **8/90 mg**	❑ **120ct**	❑ **6** ❑ **12** ❑ **Other** _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Last 4 SSN: _____ Sex: ❑ M ❑ F

Patient Address: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Best Time: _____

Email: _____

Preferred Method of Contact: ❑ Phone ❑ Email

PRESCRIBER INFORMATION

Prescriber Name: _____

State Lic #: _____ NPI #: _____

Office Address: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Office Contact Name: _____

Phone #: _____ Fax #: _____

Email: _____

Preferred Method of Contact: ❑ Phone ❑ Fax ❑ Email

PATIENT INSURANCE INFORMATION

Rx ID #: _____ Rx Group: _____ Rx Bin #: _____ Rx PCN: _____

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Prescriber Signature: _____ Date: _____

Prescriber Signature Required – Stamps Not Accepted • **Questions: Please call (833)-343-0204**

Reset