Faxed prescriptions will only be accepted from a prescribing practitioner.

vyleesi® (bremelanotide injection)

Patient Prescription Form

Select and fax your Rx to KnippeRx.

☐ KnippeRx®

knipperx.com
Fax: 833-546-0611
Ph: 833-912-0764

If you have questions or concerns, please contact KnippeRx.

1. Patient Information

Patient Name: _____

Date of Birth: _____ Known Allergies: _____ NKDA: ☐

Preferred Phone: _____ ◯ cell ◯ home ◯ work Email (optional): _____

Home Address: _____ City: _____ State: _____ Zip: _____

If Different, Ship to _____ City: _____ State: _____ Zip: _____

2. Insurance Information *Please fax FRONT and BACK copy of ALL insurance cards (prescription and medical)*

Primary Insurance: _____ Secondary Insurance: _____

Name: _____ Phone: _____ Name: _____ Phone: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

3. Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID: _____

Address: _____ Phone: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: _____

4. Diagnosis/Clinical Information

Has your patient been diagnosed with hypoactive sexual desire disorder (HSDD)? If yes, please check here, and bill to ICD-10-CM code F52.0: ☐

Is the patient greater than 18 years old ☐ Yes ☐ No

Is the patient premenopausal ☐ Yes ☐ No

Has the patient experienced HSDD for ☐ Less than 6 months, ☐ More than 6 months

Does the patient have uncontrolled hypertension or cardiac disease ☐ Yes ☐ No

Vyleesi ordered as the only on-demand FDA approved treatment for HSDD ☐

Is HSDD Diagnosis due to co-existing:

- Medical or Psychiatric Condition ☐ Yes ☐ No
- Problems with relationships ☐ Yes ☐ No
- Other medication or drug substances ☐ Yes ☐ No

Current medications: _____

Please attach Clinical/Progress Notes _____

5. Prescription Information

Dispense Vyleesi as follows:

☐ Vyleesi 1.75 mg/0.3 ml Prefilled Single-dose Autoinjector Quantity #4 Single-dose Autoinjectors NDC 80064-141-04

Directions: Inject subcutaneously as needed at least 45 minutes before anticipated sexual activity. No more than 1 dose per 24 hours. More than 8 doses per month is not recommended.

Refills: ☐ PRN or ☐ # _____

Additional Prescribing Info: _____

☐ The Specialty Pharmacy is authorized to submit to a Payer a required completed Prior Authorization form on my behalf.

Prescriber Signature: Please sign and date below

_____ _____

Dispense as written Date