XHANCE™
(fluticasone propionate) nasal spray 93 mcg

XHANCE

Prescription Referral and Enrollment Form

Phone #: 877-811-1012
Fax #: 833-261-7584

KnippeRx™
Specialty Pharmacy Services

1 Patient Information

Patient Name:_____
DOB: ____/____/_____ Sex: ☐ M ☐ F
Street Address: _____
_____
City: _____ State: ____ Zip: _____
Mobile Phone #: (____) _____ - _____
Alternate Phone #: (____) _____ - _____

Email: _____
Allergies: _____
_____
Patient Emergency Contact:_____
Relation to Patient: ☐ Self ☐ Spouse
☐ Parent ☐ Child ☐ Other:_____

2 Insurance Information

Plan Name:_____ Rx BIN: _____ Rx PCN: _____
Member ID: _____ Group: _____ Primary Acct Holder: ☐ Y ☐ N
Insurance Phone #: (____) _____ - _____ Policy holder Name: _____ Date of Birth: ___/___/_____

****Please include a faxed copy of insurance card (front and back), if available****

3 Clinical Information

Diagnosis: ☐ J33.0 Polyp of nasal cavity ☐ J33.1 Polypoid sinus degeneration ☐ J33.8 Other polyp of sinus
☐ J33.9 Nasal polyp, unspecified ☐ Other Dx codes:_____

Most Recent Steroid Treatment:
☐ Flonase ☐ Dymista ☐ QNASL ☐ Nasonex ☐ Nasacort ☐ Rhinocort
☐ Other:_____

Approximate Start / End Date of recent treatment: ___/___/_____ to ___/___/_____
Surgical History:_____

4 Prescriber Information

Prescriber Name:_____ NPI: _____ State Lic #: _____
Organization Name: _____ Office Contact: _____
Street Address: _____ Specialty: ☐ Allergist
_____ ☐ ENT
City: _____ State: ____ Zip: _____ ☐ Other: _____
Office Phone #: (____) _____ - _____ Fax #: (____) _____ - _____

5 Prescription

Rx: XHANCE (Fluticasone propionate) nasal spray 93 mcg. NDC: 71143-375-01

☐ 1 spray per nostril twice daily: Dispense 1 unit
☐ 2 sprays per nostril twice daily: Dispense 2 units

Refill(s) [please circle]: 1 2 3 4 5 6 12

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. **Date:**____/____/_____

Please complete and sign the form. Fax completed form to 833-261-7584.

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