This form is for prescriber use only. All information below is required.

Submit By Phone: 1 (833) 926-3384 | Submit By Fax: 1 (650) 683-9775

Please confirm your patient has been contacted by Cost Plus Drugs before submitting.

Patient Name: _____ DOB:_____

Sex (assigned at birth): ☐ Male ☐ Female Phone Number: _____

Address: _____

Email Address: _____ *Must match email used on costplusdrugs.com*

Insulin Lispro U100 10 mL Vial (NDC: 0002-7737-01)	**Insulin Lispro U100 15mL Box of KwikPens®** (NDC: 0002-8222-59)
Quantity (# of Vials - 10mL each) per 90 Days:	Quantity (# of Boxes - 15mL each) per 90 Days:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 (Max)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 (Max)
1 = 1,000 units 2 = 2,000 units etc.	*1 = 1,500 units 2 = 3,000 units etc.*
	We cannot dispense partial boxes of KwikPens®
Max. dose per day: _____ Units	Max. dose per day: _____ Units *MDD must be at least 33 units per day for KwikPens®*
Sig: _____	Sig: _____
_____ *Day Supply must be 61-90*	_____ *Day Supply must be 61-90*
No Refills	**No Refills**

Prescriber Name: _____ NPI:_____

Phone Number: _____ Fax Number: _____

Address: _____

Email Address (Optional): _____

Signature: _____ Date: _____

Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.
Your state may require that prescriptions follow certain content requirements or use a particular form. By signing above, you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing.

Questions? Email insulintest@costplusdrugs.com