Xubex®
P.O. Box 1244 Winter Park, FL 32790-1244
Phone: 407-478-2663 Fax: 407-671-7960
http://www.xubex.com

Free Diabetes Kit Prescription Form

Please Use this application form to apply for Xubex® Trial Prescription program. Offer can end or change without notice. If you have Medicare or private prescription insurance you are not qualified for this program. We can process your request through your provider listed in the application if one is provided. Quantity limitations applies to all offers. Refills may be purchased from Xubex® mail service at reduced rate. Visit http://www.xubex.com for price and availability.

Patient Information

First Name		Mi		Last Name	
Address				Apt.	
City		State		Zip	
DOB		Gender		SSNumber	
Phone				Alt. Phone	
Email Address					

Physician Information

Physician Name		State	
Phone		Fax	

Prescription Insurance

Insurance:_____ Bin:_____ PCN:_____
ID Number: _____ Group Number:_____ Phone Number: _____

Medicare Insurance

Medicare ID:_____

Please include a copy of your Medicare card.

Drug Allergies

☐ Codeine (32)	☐ Sulfa (87)	☐ Penicillin (70)	☐ Tetracycline (93)	☐ Other(00)	☐ Unknown (00)

Additional Allergies

Health Conditions

☐ Diabetes (200)	☐ Hypertension (300)	☐ Heart Disease (400)	☐ Glaucoma (500)	☐ Stomach Disorders (600)
☐ Thyroid Disease (700)	☐ Arthritis (800)	☐ No Known Health Condition (000)	☐ Other(000)	☐ Unknown (00)

Other Health Conditions

Patient Signature:_____ Date:_____

Physician's Instructions

In order to facilitate your patient's request, please have your patient complete the application form. Fax or mail the completed, signed form to Xubex® for processing. Free medication will be shipped within one to two weeks after a complete prescription form is received. DEA number is required for all controlled medications. Faxed prescriptions are accepted only from the physician's office. All other requests must be mailed to the address above. Incomplete Prescriptions will not be processed.

FreeStyle® Blood Glucose Meter

Other Instructions: _____

Physician's Signature: _____

Physician's DEA Number: _____

Physician's NPI Number: _____

Diagnosis Code:_____

Date: _____ Refill: 1 2 3 4 5 6 NR

I authorize Xubex® to administer the following:
1) Use any information that I provide in my application to enroll in the program.
2) Receive and keep records of all prescriptions for the medications I receive under the Program.
3) Contact my doctor, healthcare provider, or pharmacist about my application for the Program, and disclose to them information contained in my application.
4) Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. I also authorize my doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested.
5) Contact potential sources on my behalf in order to determine if I am eligible for other funding, or assistance program and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.
6) I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Program and for a period of 3 years after my participation in the Program ends. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify Xubex® of any change in my insurance eligibility.