Mobile Prescription Therapy for the self-management of type 2 diabetes
FDA Cleared / Rx Only

Prescription & Service Request
Fax to 1-866-600-5236
Customer Support: 1-888-611-4794

Patient & Insurance Information

First Name__________ Last Name__________ Date of Birth__________ ☐ Male ☐ Female

Home Address__________ City__________ State______ Zip__________

Primary Phone__________ ☐ Work ☐ Cell ☐ Home Email__________

Insurance Information (Please fill out OR attach copy of front & back of insurance card and prescription drug card)

Primary Insurance__________ ID#__________ Group#__________

Subscriber's Name *(if not self)*__________

Secondary Insurance__________ ID#__________ Group#__________

Subscriber's Name *(if not self)*__________

Rx Drug Card Name__________ Member ID#__________ RxPCN________ RxBIN__________ RxGRP__________

Patient Authorization

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy or other health care provider to disclose my personal health information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription to WellDoc, its affiliates and their representatives, agents and contractors for BlueStar Diabetes Self-Management Medical Software purposes, including but not limited to: investigating insurance coverage; obtaining payment; fulfilling and coordinating delivery; assisting with product training; providing product support; and any internal use by WellDoc, or to comply with the law. I understand that there is the potential that information disclosed under this authorization may be redisclosed by a third party and no longer protected by federal laws. I understand that I may refuse to sign this authorization, and my refusal will not affect the commencement, continuation or quality of my treatment by my doctor(s). This authorization expires 5 years after the date of signature, unless I revoke it earlier by sending written notice of revocation to BlueStar Customer Care, 6931 Arlington Rd, Suite 308, Bethesda, MD 20814, and I may receive a copy of this authorization. I confirm that my name and insurance information provided is correct.

▶ **Patient's Signature X**__________ **Date**__________

Clinical Information

▶ **Enter the most recent A1C:**

A1C __________ Date__________

▶ **Indicate A1C/BG Targets:**

☐ A1C< 7.0% *(default if no target is designated)*
BG Targets: Fasting 80-130 mg/dL
Post Prandial 80-179 mg/dL
Bedtime 90-150 mg/dL

☐ A1C < 8.0%*
BG Targets: Fasting 90-150 mg/dL
Post Prandial 90-200 mg/dL
Bedtime 100-180 mg/dL

▶ **Attach a copy of the most recent:**

☐ *BP (or write in)*__________*Date*__________
☐ *Labs (lipids, creatinine/eGFR, urine, microalbumin/creatinine ratio)*
☐ *Medications*
☐ *Medical history/problem list*

** The American Diabetes Association states that less stringent glycemic goals may be appropriate in patients with a history of severe hypoglycemia, limited life expectancy, advanced macro-vascular or microvascular complications and extensive comorbid conditions, and in those with longstanding diabetes in whom the general goal is difficult to attain despite DSME, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin.*

Certification of blood glucose targets enables BlueStar to send appropriate feedback and recommendations about blood glucose management to the patient.

BlueStar is indicated for use by adults with type 2 diabetes age 21 years and older. Not intended for people who have type 1 diabetes, are pregnant or are currently using an insulin pump.

Diagnosis: ICD-10 Code E11.9 (ICD-9 Code 250.00) will be used for this type 2 diabetes therapy unless specified otherwise: __________

Prescriber Information

First Name__________ Last Name__________ (MD/DO/CRNP/PA), NPI#__________

Practice Name / Institution / Dept__________ Office Contact Person__________

Address__________ City__________ State______ Zip__________

Phone__________ Fax__________

Prescription and Provider Authorization (NDC# 89129-0100-01 or 89129-100-01)

☐ **Dispense 30 days of BlueStar (1 unit) and 11 refills.**

☐ **Dispense 30 days of BlueStar (1 unit) and ________ refills.**

(First fill includes BlueStar new start training. Fills and refills are subject to standard billing and payment policies unless otherwise determined.)

I certify the prescribed therapy is medically necessary for the treatment of type 2 diabetes and acknowledge that BlueStar is not intended to replace the care provided by a licensed healthcare professional. I certify that this information is accurate to the best of my knowledge.

▶ **Prescriber's Signature X**__________ **Date**__________

Fax this form and requested attachments to: 1-866-600-5236

COM-002-1064-8a

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