URGENT PRODUCT REQUEST FORM: ABBOTT METABOLIC FORMULAS & SIMILAC® PM 60/40*

- Please fax both this form and physician order to **1-877-293-9145**
- Physician order should include: patient name, date of birth, product name, amount of product per day or month, duration of product use requested, doctor name, contact phone number, DEA or NPI number, and physician signature

Patient Name: _____

Patient Phone Number: _____

Product:

☐ Calcilo XD®	☐ Cyclinex®-1	☐ Cyclinex®-2	☐ Glutarex®-1
☐ Glutarex®-2	☐ Hominex®-1	☐ Hominex®-2	☐ I-Valex®-1
☐ I-Valex®-2	☐ Ketonex®-1	☐ Ketonex®-2	☐ Phenex®-1
☐ Phenex®-2 Unflavored	☐ Phenex®-2 Vanilla	☐ Pro-Phree®	☐ Propimex®-1
☐ Propimex®-2	☐ ProViMin®	☐ Similac® PM 60/40*	☐ Tyrex®-1
☐ Tyrex®-2			

Amount Needed *(only these options)*: ☐ **1 case** ***or*** ☐ **2 cases** (1 case = 6 cans)

Shipping Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Shipping Address Type: ☐ **Patient Home** ***or*** ☐ **Hospital**

* *For hospitals ordering Similac PM 60/40 for an urgent patient need, please order directly from Abbott as a standalone order (item #00850), in addition to submitting this form.*

Metabolic Center/Hospital Name: _____

Physician Name: _____

Metabolic RD or Other HCP Name *(if applicable)*: _____

Physician or Office Phone Number: _____

Physician or Office Email: _____

Healthcare Professional Name: _____

Healthcare Professional Signature: _____ Date: _____

☐ **By checking this box, you attest that the patient need has been determined urgent by a physician.**

If a patient needs additional product, please re-submit this form. For patients being discharged from the hospital with an urgent need for these products at home, healthcare professionals should submit this form along with a physician order.

By submitting this form and your patient's information, you represent and warrant that you've obtained any necessary consents or authorizations from your patient to disclose their information to Abbott Nutrition and its contracted third parties.