SOBI Medical Information Request Form

SOBI Employee:
Tel:
E-mail address:

Practitioner First Name (Print):	Practitioner Last Name (Print):
Degree/License (check all that apply): ☐ MD ☐ OD ☐ DO ☐ PhD ☐ PharmD ☐ MS ☐ PA ☐ NP ☐ Other: _____	
Address: Institution: Street Address: City: State: Zip:	Tel: Fax: E-mail:
Method of how request was received: ☐ Phone ☐ E-mail ☐ Mail ☐ Fax ☐ Direct Contact ☐ Verbal ☐ Other: _______	
Contact Method: ☐ Phone ☐ E-mail ☐ Mail ☐ Fax ☐ No Response Required [MSL only]	
Product :	
Question Type: ☐ Efficacy Data ☐ Safety Data ☐ Dosing ☐ Side Effect ☐ Other: ________________	
Describe in detail the specific question or request:	
MSL visit requested ☐ URGENT (within 2 weeks) ☐ROUTINE (within 4 weeks) ☐ NONE	
Is your inquiry related to an Adverse Event? ☐ YES ☐ NO	
If yes has the Adverse Event been reported? ☐ YES ☐ NO	

I requested this information independently and solely for my own evaluation and application to my practice, patients or general education, or for the pharmacy and therapeutics committee. I understand that in order to respond appropriately to my question or request for information there may be information related to uses not approved by the FDA distributed to me in response.

Practitioner Signature: ________________________________ Date: ________________

Telephone number for US Medical Information call center: 866-773-5274
Sobi Medical Information mailbox: medinfo.us@sobi.com