Medical Information Request

Medical Information Request

tolmar

970-999-3907 TolmarProductSupport@tolmar.com 1-844-4TOLMAR (486-5627)

Please complete the form below. Submit form via fax or email listed above.

1 Contact Information Complete all contact information (one requesting HCP per form)

NAME OF HEALTHCARE PROFESSIONAL (PLEASE PRINT)		TITLE (IF ANY)

TYPE OF HCP

☐ M.D. ☐ D.O. ☐ Ph.D.. ☐ R.Ph. ☐ R.N. ☐ Pharm.D. ☐ Other _____

INSTITUTION NAME OR OFFICE/PRACTICE NAME

ADDRESS		BLDG./SUITE

CITY	STATE	ZIP

TELEPHONE	FAX

EMAIL	PREFERRED METHOD OF RESPONSE
	☐ Mail ☐ Email ☐ Fax ☐ Phone

2 Inquiry Please provide specific details regarding your inquiry in the space below

The product you are inquiring about: ☐ Eligard ☐ Fensolvi

3 Signature Please sign and date

Request Not Valid Without Healthcare Professional's Signature Below. By signing below, I hereby confirm that the medical information and/or inquiry requested was at my initiation and was not solicited in any manner by a Tolmar Pharmaceuticals sales person or other personnel. The wording above accurately reflects the medical information I hereby request to be provided to me by Tolmar Medical Affairs.

HEALTHCARE PROFESSIONAL'S SIGNATURE (REQUIRED)	DATE

Tolmar Use Only

TOLMAR ACCOUNT MANAGER NAME		REGION

PHONE	EMAIL