DIEM DIRECT

NEW PRESCRIPTION FAX FORM FAX: 1.307.316.0328

STEP 1 Complete all information in this section

Patient Information

Name: _____ Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home phone #: _____ Cell phone #: _____

Best time to contact: ☐ AM ☐ Mid-Day ☐ PM Preferred contact method: ☐ phone ☐ text ☐ email

Prescriber information

HCP Name: _____

NPI #: _____ DEA #: _____ Rx Contact Person: _____

Office phone #:: _____ Fax #: _____

Office Address: _____

City: _____ State: _____ Zip: _____

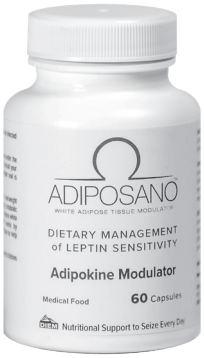
STEP 2 Fill in prescription information below

Adiposano™

☐ Take 2 Capsules Daily

☐ Take ___ Capsules Daily

☐ 90 days
☐ 180 days
☐ 365 days
☐ _____



#60 capsules

Adiposano™

is indicated for the distinct nutritional requirements of individuals with excess white adipose tissue syndrome* or metabolic dysfunction who present with a BMI ≥30, inflammatory adipokine/cytokine imbalance and leptin resistance.

Signature: _____ Date: ____ /____ / ____

Stamps are not accepted. Signature required.

STEP 3 Sign this prescription and fax to DIEM Direct Product Distribution Center

1.307.316.0328

Fax from the prescriber's secure fax line / Cover sheet is not required / Incomplete forms will cause a delay in processing.

Fax: 1.307.316.0328 Phone: 1.800.971.3721 EXT. 2 Email: feelbetter@diemlabsllc.com