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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: _____

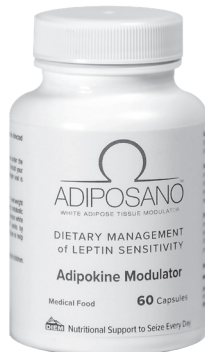
STEP 2

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.