Medical Information Request Form

Form MED04-01

INSTRUCTIONS

1) Complete ALL fields of form **legibly**.
2) Include only ONE healthcare professional per form.
3) Fax completed form to Amarin Pharma Medical Information at (919) 654-3703 or email electronic form to amarinmi@druginfo.com

Send Form

Method of Response

☐ Mail
☐ Fax
☐ Email

HEALTHCARE PROFESSIONAL (HCP) CONTACT INFORMATION

Date of Request: _____

Requestor's Name: _____ Specialty: _____

Degree: ☐ MD ☐ DO ☐ RN ☐ RPh ☐ PharmD ☐ PA ☐ Other _____

Institution/Office Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____

Email: _____

HCP Signature (**Required**) _____

Information Requested:

Sales Professional/Account Manager/Amarin Representative Contact Information

By submitting this form, I certify that this request for information was initiated by the healthcare professional stated above, and was not solicited by me in any manner.

Submitter Name_____

Telephone Number_____

Effective: 09/20/12