

Pfizer Inc.
 275 North Field Drive
 Lake Forest, IL 60045



[Email form to: PISupplyContinuity@pfizer.com](mailto:PISupplyContinuity@pfizer.com)

Email **must be received from the Electronic Signature Email Address listed below*

For questions contact the Supply Continuity Team at 1-844-646-4398 (select option 1 [Customer], then option 3 [Supply Continuity Team]).

Date Request Submitted (MM/DD/YYYY)

Product Description	NDC
Solu-Cortef™ (hydrocortisone sodium succinate for injection, USP) 100 mg/2 mL (50 mg/mL) ACT-O-VIAL™ Single Dose Vial	00009-0011-03

Healthcare Facility Detail Section	
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Healthcare Facility's Name	
Healthcare Facility's Contact Name	
Healthcare Facility's Phone Number	
Healthcare Facility's Address	
Healthcare Facility's DEA Number or HIN Number	
Healthcare Facility's Pfizer Customer Number	
Healthcare Facility's Primary Wholesaler: Name and City	

Patient Need Section	
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* Do NOT include Patient information	
Does the Physician understand the product is in critically short supply and may become unavailable at any time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
This product is necessary for the patient and there are no immediate suitable alternatives.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your primary wholesaler stocked out?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to obtain product within the hospital system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current quantity on hand? (number of vials)	
Number of vials needed?	
How many active patients do you have in need of this product?	
What is date the product is needed by? (MM/DD/YYYY)	
Please provide a Purchase Order Number for the order.	

Expedited Shipping Section	
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All customer requested expedited shipments will incur a \$25 handling fee plus applicable shipping charges (shipping charges subject to change dependent on weight and shipping time requested).	
Would you like expedited overnight shipping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do you approve \$25 S&H Fee + a variable fee based on the weight of the shipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Comments	

*Treating Health Care Provider or Director of Pharmacy (or above) Electronic Signature <i>(Typing your name in this form is considered your electronic signature)</i>	
*Treating Health Care Provider or Director of Pharmacy (or above) Email Address	

***Requests will be reviewed and filled in the order they are recieved and only with the required documentation.
Each additional product need will require a separate form filled out and emailed.
For overnight requests, orders must be placed by 3 p.m. (CT).***