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

Pfizer Hospital

Email form to: 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**

Heathcare Facility Detail Section	
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	
*** Do NOT include Patient information**	
Does the Physician understand the product is in critically short supply and may become unavailable at any time?	☐ Yes ☐ No
This product is necessary for the patient and there are no immediate suitable alternatives.	☐ Yes ☐ No
Is your primary wholesaler stocked out?	☐ Yes ☐ No
Are you able to obtain product within the hospital system?	☐ Yes ☐ 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	
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?	☐ Yes ☐ No
If yes, do you approve $25 S&H Fee + a variable fee based on the weight of the shipment?	☐ Yes ☐ No
Additional Comments	

*Treating Health Care Provider or Director of Pharmacy (or above) Electronic Signature *(Typing your name in this form is considered your electronic signature)*	
*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).