***All prescriptions are required on clinical letterhead for insurance medical review and approval purposes. ***

Physician's Written Order

Enteral Nutrition for VARVIMAX™

To place an order for your patient, please visit http://varvimax.com Lanfam LLC can help your patients navigate the insurance process and connect them with an in-network home Medical Supplier (DME).

PATIENT

First | MI | Last

DOB | Gender | Height | Weight

Street | City | State | Zip

Phone | Email

Caregiver Contact | Phone | Email | Relationship

INSURANCE

Primary Insurance Policy Holder Name | DOB | Secondary Insurance Policy Holder Name | DOB

Primary Insurance | Phone | Secondary Insurance | Phone

Policy/ID | Group # | Policy/ID | Group #

Patient's Current Home Medical Supplier

PRESCRIBING PHYSICIAN

First | MI | Last

Street | City | State | Zip

Phone | Fax | NPI#

DIAGNOSIS

Start Date: ____ /____ /_____

Estimated Length of Need: ________ months (99 = lifetime)

ICD-10 Diagnosis Code: __________

Quantity to of Capsules to Dispense PER DAY: _________

Medical records may be required for insurance coverage. Please send this form, insurance cards and appropriate clinical documentation to the medical supply company, Enteral Nutrition LLC.

I certify that I am the physician/practitioner identified on this form and I have reviewed the Physicians Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. To the extent that I provide any information to Lanfam LLC relating to the patient above, I certify that I have received the proper consent from the patient, will provide a copy to Lanfam LLC upon request, and will indemnify Lanfam LLC.

Physician/Practitioner Signature: ______________________________ Date: ____________________

(Stamps are not acceptable)

Printed Name: ______________________________