Request Sample for OFFICE

To receive your samples of NUVESSA®, complete this form to its entirety and fax or email to the following:

FAX: 614-652-8275 | EMAIL: ExeltisSamples@cardinalhealth.com

Your shipment of professional samples **may only be sent to your office address**.

PLEASE NOTE: In compliance with the Prescription Drug Marketing Act regulations, incomplete request forms cannot be processed and samples will not be forwarded.

PRACTITIONER INFORMATION

Professional Designation (Check One): ☐ MD ☐ DO ☐ NP ☐ CNM ☐ PA

First Name: _____

Last Name: _____

Address 1: _____

Address 2: _____

(Samples will not be issued or delivered to a PO Box; please provide your office street address)

City: _____ State: _____ Zip Code: _____

Telephone #: _____

Fax #: _____

E-Mail Address: _____

State License Number* [mandatory]: _____ Exp. Date*[mandatory]: _____

PRODUCT INFORMATION

Select the samples you wish to receive. Please allow 3-5 business days for delivery

☐ ITEM 0642-7466-06 NUVESSA®, 2 Boxes

PLEASE CIRCLE BEST DAY(S) AND TIME(S) TO RECEIVE SAMPLES:

MON–AM/PM **TUE**–AM/PM **WED**–AM/PM **THURS**–AM/PM **FRI**–AM/PM

I hereby certify that I am a licensed practitioner eligible to request, receive, prescribe and dispense these samples at the location above. If I am a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant, I hereby certify that I am authorized and eligible, in the state in which I am now practicing, to request and receive these samples and I have my supervising Physician's approval to do so (if applicable). I have requested these samples for the medical needs of my patients and I will not sell, resell, trade, barter, return for credit or seek third-party reimbursement for them.

_____ _____

Practitioner's Signature
(Original signature required—no stamps)

Date

NUV-24-048 R00