NUEDEXTA®
(dextromethorphan HBr and quinidine sulfate) capsules 20 mg 10 mg

Otsuka

Fax the completed form (no cover sheet needed) to: 844-474-0833 or email completed form to: OtsukaNuedexta@knipper.com

NUEDEXTA® Free Trial Vouchers Request Form

Shipment will contain requested quantity

Physician Name First : _____ Last : _____

State License Number (no abbreviations, please) : _____

Professional Designation (check one) MD ☐ DO ☐ NP ☐ PA ☐ Other : _____

Address 1 : _____

Address 2 : _____

City : _____ **State :** _____ **Zip Code :** _____

Phone : _____ **Fax :** _____

Number of Vouchers Requested (Max 10/month) : _____

Offer Details:

1. The free trial voucher is intended only for new patients who have not been prescribed NUEDEXTA® previously.
2. Only healthcare professionals who cannot accept samples are eligible to receive free trial vouchers.
3. There is a limit of one free trial voucher per new patient.
4. A patient will receive 13 free 20mg/10mg capsules with the use of one voucher.
5. Offer void where prohibited or restricted by law.
6. The free trial voucher may not be distributed or utilized in a long term care setting.

SIGNATURE BELOW INDICATES AGREEMENT TO THE FOLLOWING:

- The vouchers requested are for use in my practice for the medical needs of my patients.
- I certify that I am currently licensed with the appropriate state authorities to request, receive, and prescribe the products indicated on this request form.
- I agree that these vouchers will not be traded, sold, bartered, returned for credit, utilized for personal use, or utilized to seek reimbursement.
- I acknowledge Otsuka shall comply with federal, state, and local laws and regulations regarding restrictions or reporting of free trial vouchers.
- I am requesting trial vouchers because I cannot accept samples.

Your signature on this voucher request form serves as attestation that vouchers will not be distributed or utilized in a long term care setting.
The information you provide on this form is subject to Otsuka's privacy notice at otsuka-us.com/privacy-policy.

Licensed Physician's Signature _____ **Specialty** _____ **Date** (mm/dd/yyyy) _____

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