Fax the completed form (no cover sheet needed) to: 1 (866) 329-7771

AVANIR™ pharmaceuticals

Document Number:

Sample Signature Form

Physician Name: First _____ Last _____

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

State License No.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Date: MM/DD/YY

_____ /_____ /_____

PRODUCT DESCRIPTION	NDC CODE	SIZE	QTY.
NUEDEXTA (dextromethorphan HBr and quinidine sulfate) Capsules	30113	20 mg/10 mg	8

Signature below indicates agreement to the following:

- **The samples 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 samples indicated on this request form**
- **I understand that either my signature or the signature of a responsible person in my office will be required as a receipt of delivery**
- **I agree that these samples will not be traded, sold, bartered, or returned for credit**
- **I agree that these samples will not be submitted to any public or private third-party payor (including, without limitation, Medicaid, Medicare, private insurers, or other third parties) for reimbursement**

X

Licensed Practitioner's Signature Specialty