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

AVANIR PHARMACEUTICALS

Fax the completed form (no cover sheet needed) to: 1 (844) 465-0953
or email completed form to: avanir_nuedexta@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. If a patient is commercially insured, the free trial voucher may be redeemed at any pharmacy. Offer not valid for patients who are insured through Medicare, Medicaid, TRICARE, or any other federal or state funded health programs (such as medical assistance programs). Offer void where prohibited or restricted by law.

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 Avanir 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 distributed or utilized in a long term care setting.
The information you provide on this form is subject to Avanir's privacy notice at avanir.com/privacy.

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

www.avanir.com **Tel:** +1 (949) 389-6700 30 Enterprise, Suite 200, Aliso Viejo, CA 92656 35043002

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