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

NUEDEXTA® Sample Request Form

Shipment will contain 8 NUEDEXTA® samples/bottles.

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 :** ______________

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

NUEDEXTA® is distributed by Avanir Pharmaceuticals, Inc.

Product Description:
NUEDEXTA®
(dextromethorphan HBr and quinidine) Capsules

NDC Code:
64597-301-13

Size: 20mg/10mg 13 Capsules

Quantity: 8 Bottles

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 payer (including, without limitation, Medicaid, Medicare, private insurers, or other third parties) for reimbursement.
- I have a secure location to store the samples and in a manner consistent with the label.

Some states require a distribution license prior to accepting pharmaceutical drug samples or complimentary units, unless subject to the exemptions listed in the state laws and regulations. More information on this requirement can be found at the state board website.

Your signature on this sample request/receipt serves as attestation that you have the appropriate licensure, if required, or qualify under an exemption under the state laws and regulations.

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)

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