

# SAMPLE REQUEST FORM



Dear Healthcare Practitioner:

Thank you for your request to receive samples of **ZYPITAMAG™ (pitavastatin)** tablets. Please complete this form, print, sign and fax to 614-553-9510. Please allow 2 to 3 business days for delivery once we receive a fully completed form. Please note that each practitioner may submit only one sample request form per month.

## PLEASE SELECT THE STRENGTHS THAT YOU WOULD LIKE TO RECEIVE

CHECK SAMPLE PACKS TO BE SENT	PRODUCT	NDC Number
<input type="checkbox"/> 6 packs (each pack contains 7 tablets)	<b>ZYPITAMAG™ 1 mg</b>	25208-200-10
<input type="checkbox"/> 6 packs (each pack contains 7 tablets)	<b>ZYPITAMAG™ 2 mg</b>	25208-201-10
<input type="checkbox"/> 6 packs (each pack contains 7 tablets)	<b>ZYPITAMAG™ 4 mg</b>	25208-202-10

## HEALTHCARE PRACTITIONER'S (HCP) INFORMATION (samples can only be sent to your office address)

First Name:		Last Name:	
Address: (No P.O. Box #)			
City:		State:	Zip:
Phone:		Email Address:	Fax:
Requesting HCP State License Number or Authorization Number:			Exp Date:
Professional Designation: MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/>			List Specialty:

My signature certifies that I am a licensed practitioner eligible to receive these samples. They are being requested for the medical needs of my patients and are not intended for sale, resale, trade, barter or credit return. I understand that I may not seek or accept any reimbursement for these samples as I will not incur any cost in relation to them. I understand in order to continue to receive samples an acknowledgement of content/delivery must be signed. Medicure reserves the right to decline requests for samples from practitioners whose medical practice and/or patient population is deemed inconsistent with the approved product indication(s).

OHIO PRESCRIBERS ONLY: I understand that Ohio law (Rev Code 4729.51) requires me (or my practice) to hold a valid Terminal Distributor of Dangerous Drugs (TDDD) license or meet an exemption to receive prescription drugs, including samples. By signing this form, I certify that I (or my practice) possess a valid Ohio TDDD license for the "ship to" address on this form or I (or my practice) are exempt from the Ohio TDDD licensing requirements. Guidance from Ohio State Board of Pharmacy on prescriber licensure can be found at : [www.pharmacy.ohio/prescriberTDDD](http://www.pharmacy.ohio/prescriberTDDD).

**X** \_\_\_\_\_

**Requesting HCP's original signature required**

(No stamped signatures permitted)

\_\_\_\_\_

**Date of Signature**

**In compliance with the Prescription Drug Marketing Act regulations, incomplete request forms cannot be processed, and samples will not be sent.**

**For any questions on your order, call 844-735-5957. For any questions pertaining to the product or usage, visit [www.zypitamag.com](http://www.zypitamag.com)**

**To report SUSPECTED ADVERSE REACTIONS, contact Medicure (distributor) at 1.800.509.0544 or FDA at 1.800.FDA.1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch)**