SAMPLE REQUEST FORM

Dear Physician:
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 physician may submit only one sample request form per month and that only MDs/DOs may request samples.

PLEASE SELECT THE STRENGTHS THAT YOU WOULD LIKE TO RECEIVE

CHECK SAMPLE PACKS TO BE SENT	PRODUCT	NDC Number
☐ 6 packs (each pack contains 7 tablets)	**ZYPITAMAG™ 2 mg**	25208-201-10
☐ 6 packs (each pack contains 7 tablets)	**ZYPITAMAG™ 4 mg**	25208-202-10

PHYSICIAN'S 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 ☐ DO ☐		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.

X_____ _____

Requesting physician's original signature required **Date of Signature**
(No stamped signatures permitted)

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

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

Manufactured by: Cadila Healthcare Ltd
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