

PHARMA Sample Request Form

Terri	torv	#	
	,		

Practitioner Name:			Profession	Professional Designation:		
Street Address:		Suite Number:				
City:	St	ate:	Zip Code:			
State License Num	ber: Of	fice Phone Number:	Office Fax	Number:		
Office Contact Nar	me: Office Email Address:					
Product NDC:		Product Description:	Quantity			
82867000102	LODOCO	(0.5MG colchicine) 30TA				
PLEASE SIGN AND DATE TO RECEIVE SAMPLES						
<u>X</u>		<u> </u>				
Practitioner's Original Signature (No signature stamps) Date						

Please submit completed form to: agephasamples@cardinalhealth.com or fax to 614-553-9975

By signing and returning, I certify I am a licensed practitioner eligible to request, receive, prescribe, and dispense these complimentary samples at the location above. If I am a Nurse Practitioner or Physician Assistant, I certify I am authorized and eligible, in the state in which I am now practicing, to request and receive these samples, and I have my supervising Physician's approval to do so. I have requested these samples for the medical needs of my patients and I will not sell, resell, trade, barter, return for credit, or seek third-party reimbursement for them.

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 OhioTDDD 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.

Manufactured by: Agepha Pharma 181 New Road Suite 304 Parsippany, NJ 07054 Distributed by: Cardinal Health 501 Mason Road LaVergne, TN 37086