glydo®

(lidocaine HCl jelly USP, 2%)

SAMPLE REQUEST FAX FORM

GLYDO Sample Order Fulfillment **Fax #: 1-847-908-1888**

Your shipment of professional samples can be sent only to your office address. *Please note: In compliance with Prescription Drug Marketing Act regulations, incomplete request forms cannot be processed and samples will not be forwarded.*

Practitioner Name _____ Professional Designation ◯ MD ◯ DO
(Check One)

Specialty _____

Phone Number _____ Fax Number _____

Email _____

Address _____
(Please provide your office street address; samples will not be issued or delivered to a PO box.)

City _____ State _____ ZIP _____

Sample Product Request	Product Description	Quantity
☐ NDC 25021-673-77	**GLYDO** 11 mL single-use prefilled syringe	10 syringes (1 box)

Manufacturer: Klosterfrau Berlin GmbH
Authorized Sample Distributor: QPharma, Inc.

By signing this form I request the drug samples listed herein and certify that I am a licensed practitioner currently authorized under applicable federal and state law to request, receive, prescribe, and dispense these drug samples. I certify that I have requested these samples for legitimate medical needs of my patients. I understand that the sale or offer to sell a drug sample is a federal offense. I certify that I will not seek payment from any patient or third party payor for these drug samples and I will not sell, resell, trade, barter, return for credit, or seek reimbursement for any drug sample.

By submitting this sample request form, I agree that the information I am providing may be used by SAGENT, its affiliates or vendors to keep me informed via email about new products or other opportunities that may be of interest to me, as they become available. This information will be used in accordance with the SAGENT Privacy Policy, available at http://www.sagentpharma.com/privacy-notice.html. I can stop SAGENT from sending me future GLYDO-related communictions by clicking on the "unsubscribe" link, which will be available in future emails.

Physician Signature _____ Date _____
(Authorized physician signature–no stamped signatures allowed)

State License Number _____ Exp. Date _____

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