



SHIPMENT REQUEST



PLEASE PRINT CLEARLY

COMPLETE ALL INFORMATION

(Incomplete requests will not be filled)

Practitioner's signature and professional designation required

PLEASE SEND THIS REQUEST TO:

EMAIL: TerSeraCS@dlss.com

FAX: 855-224-0217

MAIL: TerSera Therapeutics LLC

190 N. Milwaukee St

Milwaukee, WI 53202

SHIP SAMPLE TO:

Practitioner's Last Name First Name Middle Initial (MD, DO, NP, PA) Practitioner's State License Number and expiration date

Street Address Practitioner's Phone Number

City, State and Zip Code Practitioner's Email

* PLEASE SEND THE SAMPLE PRODUCT LISTED TO THE RIGHT FOR USE IN MY PRACTICE FOR THE MEDICAL NEEDS OF MY PATIENTS.

* I CERTIFY THAT I AM AUTHORIZED AS A LICENSED PRACTITIONER TO RECEIVE THESE PRODUCTS.

* I UNDERSTAND THAT MY SIGNATURE WILL BE REQUIRED AS VERIFICATION OF RECEIPT UPON DELIVERY.

X

PRACTITIONER SIGNATURE

X

DATE REQUESTED

Product Requested:

Enter the quantity in the box below

Ergomar Sublingual Tablets 2mg
(Ergotamine Tartrate Sublingual Tablets, USP) NDC 70720-120-03

*** Maximum of 5 units per NDC can be ordered ***
All samples must be used within sampling guidelines

Manufacturer: TerSera Therapeutics LLC
Lake Forest, IL

FOR OFFICE USE ONLY =====

Order number: _____

Date Order Sent: _____