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Form ID: _____

34543003

DO NOT DUPLICATE
Please fax the completed Sample Request Form to 844-300-9408 or email to TerSera@knipper.com

Practitioner Information

* Practitioner First Name: _____ * State License: _____

* Practitioner Last Name: _____ * Telephone: _____

* Professional Designation: MD DO NP PA Other: _____ * Fax: _____

Office Name: _____ Email: _____

* Address 1: _____

Address 2: _____

* City: _____

* State: _____ * Zip Code: _____

Fields preceded with an * are required.

Product Information

Product Code	Product Description	Quantity
70720-120-03	Ergomar® (Ergotamine Tartrate) Sublingual tablets 2mg	5 Sample Cartons

Check this box to OPT-OUT of future fax or e-mail communication regarding Ergomar® drug samples

Manufactured and Distributed by: TerSera Therapeutics LLC, Two Conway Park, 150 N. Field Dr, Suite 195, Lake Forest, IL 60045

Practitioner Authorization and Signature

DATE & SIGN HERE

I certify I am a licensed practitioner eligible to request, receive, prescribe and dispense these products in compliance with applicable state and federal laws. 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 products and that I have my supervising Physician's approval to do so. I have requested these products for the medical needs of my patients. I will not sell, resell, trade, barter, donate, return for credit or seek third-party reimbursement for them.

For Ohio licensed healthcare professionals: the Ohio Board of Pharmacy requires Terminal Distributors of Dangerous Drugs to obtain a TDDD license prior to accepting pharmaceutical drug samples or complimentary units, unless subject to the exemptions listed in ORC 4729.541. More information on Ohio's requirement can be found at <http://www.pharmacy.ohio.gov/PrescriberTDDD>. Therefore, if you are an Ohio licensed healthcare professional who claims an exemption to the terminal distributor of dangerous drug licensing requirement, by checking the box below you attest that you meet one of the licensing exemptions under ORC 4729.541. Your signature on this sample request form serves as attestation and that you have the appropriate TDDD licensure or qualify under an exemption.

Ohio TDDD Exemption

X*

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Date (MMDDYYYY)

X*

Licensed Practitioner's Signature

* This request cannot be filled unless this form is signed and dated in ink. Signature must be original, not signature stamp.

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