TherapeuticsMD®

*For Her. For Life.*

# SAMPLE REQUEST FORM – FAX TO 866-884-7286

| PRESCRIBER INFORMATION | | | | |
|---|---|---|---|---|
| First Name: | | Last Name: | | |
| Designation*: (circle one)* ☐ MD ☐ DO ☐ PA ☐ NP Other _____ | | State License #: | | Expiration Date *(MM/DD/YYYY):* |
| Street Address: *(PO Boxes are not accepted)* | | | | |
| City: | | State: | | Zip Code: |
| Telephone: | Fax: | | Email: | |

| PRODUCT REQUEST | | | | |
|---|---|---|---|---|
| **NDC** | **Product** | **Strength** | **Description** | **Quantity** |
| 50261-104-02 | IMVEXXY® (estradiol vaginal inserts) | 4 mcg | 2 count Professional Sample | *Max: 20* |
| 50261-110-02 | IMVEXXY® (estradiol vaginal inserts) | 10 mcg | 2 count Professional Sample | *Max: 20* |

This form must be filled out completely before your sample request can be processed. You should expect samples to arrive within 2-7 business days from the date your fax request is received. If you have any questions regarding your request, please call 1-(844)-787-4994 (M-F 8am–5pm EST)

I certify that I am a licensed practitioner and am eligible to request and receive prescription drug samples. I have requested the packaged quantities of the product indicated above for the legitimate medical needs of my patients. I will not seek payment from any patient or third-party payor for these samples, and I will not sell, resell, trade, barter, return for credit or seek reimbursement for any drug sample. I understand that samples will be mailed directly to my office along with an Acknowledgment of Contents Form, that must be signed and returned to TherapeuticsMD upon the delivery of samples.

TherapeuticsMD 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).

**REQUEST CANNOT BE FULFILLED UNLESS THIS FORM IS SIGNED AND DATED. MUST BE ORIGINAL, NO SIGNATURE STAMPS ACCEPTED.**

**Prescriber Signature (required)** **Date (required)**