Sample Request Requirements

INTERNAL USE ONLY	
Processed by:	Date:
Order #	
Prescriber #	
Rejected by:	Date:
Reason	
Sales Rep	Date:
Signature:	
Territory Number:	

SEND TO: **Mylan Specialty L.P.** **Attn: Customer Relations**
FAX #: **1-304-285-6418**
EMAIL: **CR.Sampling@viatris.com**

NO. YUP49773

Healthcare Professional (HCP) Sample Request Form for:

YUPELRI® (revefenacin) inhalation solution 175 mcg
7 unit-dose vials

NDC: 49502-806-87

Manufactured for and distributed by Mylan Specialty L.P.

Please circle requested quantity: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 cartons

NOTE: A maximum of one request per licensed prescriber per day will be processed

Healthcare Professional's Name _____
Please Print (First Name) (Middle Initial) (Last Name)

Professional Designation: ☐ MD ☐ DO ☐ PA ☐ NP HCP's State License #: _____ State: ☐☐

NPI #: _____

Address (no PO Box #): _____

City: _____ State: ☐☐ Zip: ☐☐☐☐☐-☐☐☐☐

Note: Shipments will only be made to a registered state license address. For Ohio HCPs, the address must match the TDDD license.

Phone: ☐☐☐-☐☐☐-☐☐☐☐ Fax: ☐☐☐-☐☐☐-☐☐☐☐

I certify, by signing below, that I am a licensed practitioner authorized by state and federal law to prescribe, request and receive these drug samples. I am requesting these samples for the medical needs of my patients and will <u>not</u> sell, purchase, trade, barter, return for credit, or offer to do so, or seek reimbursement for these samples.

HCP's Signature: _____ Date: _____
(HCP must sign and date. Stamped signature not accepted.)

<u>MANDATORY SECTION FOR ALL OHIO HCPs</u>

Under Ohio law, Mylan Specialty L.P. may only provide drug samples to a prescriber whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity to receive, purchase, and possess prescription drugs, including drug samples, for distribution to patients. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at <u>www.pharmacy.ohio.gov/PrescriberTDDD</u>, and for a list of exemptions, please refer to section 4729.541 of the ORC. The above information is being provided for your convenience and is not offered, nor should it be construed, as legal advice.

Please select and complete one of the following:

☐ The practice at which I work, [insert name] _____, located at the address I provided above, has an active TDDD license that allows me to receive and store the requested samples at this location. The TDDD license number is _____ and expires on _____.

OR

☐ The practice at which I work, [insert name] _____, located at the address I provided above, is subject to one of the TDDD licensing exemptions in ORC § 4729.541.

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested samples at the address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

HCP's Signature: _____ Date: _____
(HCP must sign and date. Stamped signature not accepted.)

In compliance with the "Prescription Drug Marketing Act", ONLY valid, COMPLETED, SIGNED, and DATED Sample Requests will be processed. In addition, Healthcare Professional or authorized designee must sign, date, and fax Acknowledgement of Contents form to Mylan Specialty L.P. upon delivery of sample shipment.

This sample request form is only valid until 6/30/2024. Expired forms will not be processed.

VIATRIS™