

EXPRESS REQUEST FOR SAMPLES

ATTENTION

Please deliver this form to the physician so that requested samples may be delivered promptly.

Job Number: 7050021 :20 Frova

DELIVER TO:

FROM: Endo Pharmaceuticals

First Name: _____

Last Name: _____

Address 1: _____

Address 2: _____

Address 3: _____

City/State/Zip: _____

Phone: _____

Fax: _____

State License#: _____ (Please fill in)

Authorized Distributor: Triple i

Manufactured by: Endo Pharmaceuticals

INSTRUCTIONS FOR REQUESTING SAMPLES:

To obtain samples of the product listed below, please complete the following: (1) check the appropriate box to confirm samples requested, (2) sign your name, (3) indicate professional designation, (4) date and (5) fax this form back to **1-800-233-9141**

To opt-out of receiving additional fax information please visit <http://www.aristamktg.com/donotfax/>

FROVA® (Frovatriptan Succinate) 2.5mg Tablets (Item 6348102512 – 6 Blister Packs - Qty – 12)

- * *The samples requested are for use in my practice for the medical needs of my patients.*
- * *I certify that I am authorized as a licensed practitioner to receive this product.*
- * *I understand that either my signature or the signature of a responsible person in my office will be required as a receipt of delivery.*
- * *I agree that these samples will not be traded, sold, bartered for or returned for credit.*
- * *I agree that these samples will not be submitted to any third party payer, public or private (including, without limitation Medicaid, Medicare, Private insurers, or other third parties), for reimbursement.*

Practitioner Signature (no stamps, please)

Professional Designation

Date

****Please confirm your address listed above before faxing back this original document.****

*******Upon receipt of this order, samples will be shipped to you within 4-6 weeks.*******

Fax completed form (no cover sheet needed) to: **1-800-233-9141**

Project: Frova 2008

Arista Marketing Associates

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