

**DIOVAN and DIOVAN HCT
Rx SAMPLE REQUEST FORM
Return Completed Form via Fax to: 1-888-697-7607**

Dear Licensed Practitioner:

Thank you for requesting samples from Novartis Pharmaceuticals Corporation. In order to expedite your sample request, please complete the information below and fax to the number listed above. **Incomplete requests will not be processed.** Shipping is via UPS. Please allow 5–10 business days for delivery. For any product-related questions concerning DIOVAN or DIOVAN HCT, please call **1-877-HYPER-10 (1-877-497-3710)**.

MD DO NP PA

Practitioner's Last Name, First Name

State License Number

Expiration Date

ME Number

Print the STATE LICENSE NUMBER exactly as it appears on the certificate. This number is required to allow samples to be sent.

Address (No P.O. Boxes)

City, State, ZIP Code

Phone #

Fax #

Please select to receive:



- 8 units of DIOVAN 160 mg
- 4 units of DIOVAN 320 mg



- 8 units of DIOVAN HCT 160/12.5 mg
- 4 units of DIOVAN HCT 320/25 mg

Please see accompanying full Prescribing Information, including **Boxed WARNING** for DIOVAN and DIOVAN HCT or please go to www.quo.novartis.com/product/DIOVAN.

SIGNATURE REQUIRED Original ink-written signature of licensed practitioner required (**no signature stamps**).

X

Date of Signature

My signature certifies that I am a licensed practitioner eligible to request and receive these samples. The samples are being requested for the medical needs of my patients and are not intended for, and are prohibited from, sale, trade, barter, and return for credit. I understand that I may not seek or accept any reimbursement for these samples as I will not incur any cost in relation to them. I understand that Novartis Pharmaceuticals Corporation will mail these samples directly to my office and that I will be required by federal law to sign an acknowledgement of delivery.

As per federal regulations, incomplete requests cannot be processed.