VELPHORO®
(sucroferric oxyhydroxide)
chewable tablets

32416002

DO NOT DUPLICATE

Please fax the completed Sample Request Form to 1-855-812-7818
or email to: Fresenius_DTP@knipper.com

Practitioner Information

* HCP First Name:________________________Middle Name:______ * State License: ________________________

* HCP Last Name:___________________________Suffix:_________ DEA #: _____________________________

* Professional Designation:☐MD ☐DO ☐NP ☐PA ☐Other:_______Specialty: ___________________________

Company Name:____Phone: ______________________________

* Address 1:____Fax: _________________________________

Address 2:____Email: ______________________________

* City:____Secondary Authorization #: _______________

* State:_______________ * Zip Code:_________________ Fields preceded with an * are required

Product Information

NDC Code	Product Description	Quantity
49230-645-52	**VELPHORO®** (sucroferric oxyhydroxide) 500mg 1x30 chewable tablets	**4**

INSTRUCTIONS FOR REQUESTING SAMPLES

Thank you for your interest in product samples. Please follow the steps outlined below to assist in ensuring efficient delivery.
(1) Please verify all information is accurate on the form, including state license information, complete shipping address (no PO boxes), phone and fax, and correct as necessary, using blue or black ink to fill in all appropriate fields.
(2) Select the amount of samples that you would like to receive by circling one of the quantity options. If no selection is made, the order quantity will default to 4 units.
(3) Sign your name, provide your professional designation above and date the form.
(4) Fax the form to 1-855-812-7818 or email it to Fresenius_DTP@knipper.com

Manufactured for and Distributed by: Fresenius Medical Care North America

Practitioner Authorization and Signature

Your signature below indicates agreement to the following:
- The samples above are requested for use in my practice for the medical needs of my patients.
- I certify that I am authorized as a licensed practitioner to request and 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, or returned for credit.
- I agree that these samples will not be submitted to any public or private third-party payor (including, without limitation, Medicaid,Medicare, TRICARE, private insurers, or other third parties) for reimbursement.

DATE & SIGN HERE X* ☐☐☐☐☐☐☐☐ X* ☐

Date (MMDDYYYY) **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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