TAVNEOS® (avacopan)

Form Exp. 12/31/2026

Amgen Sample Request Form
DO NOT DUPLICATE
Complete form and fax to (855) 697-4650 or email to AmgenSRF@knipper.com

Sample Accountability may be reached at (888) 58-AMGEN.

Name (First)* (M.I.) (Last)*

Professional Designation*: ○ MD ○ DO ○ NP ○ PA

State License Number* Specialty*

Office Street Address* (Cannot ship to P.O. Box)

City* State* Zip Code*

Telephone* Email*

*Required Field

PRODUCT INFORMATION:

NDC	Product Description	Quantity (units)
73556-168-96	TAVNEOS® (avacopan), 10 mg capsules, 5-day bottle (1 patient sample = 2 units)	2 units

Manufactured for Amgen, Inc. by: Thermo Fisher Scientific 2110 East Galbraith Road, Cincinnati, OH 45237 USA.

IMPORTANT NOTICE AND ATTESTATION:

The purpose of drug samples is to allow a licensed prescriber to gain on-label experience with the sampled product or to provide a trial period for a patient. ***Drug samples are strictly regulated under federal law.*** Criminal penalties may apply to falsification of drug sample requests, receipts, or records; and the diversion (including the sale, purchase, or barter) or theft of drug samples. Similarly, it is a violation of federal law to return for credit or otherwise charge for or submit for billing any units of drug samples to the patient or any third party. Amgen must report to federal authorities if it has reason to believe any of the above has occurred.

In requesting the sample product and quantity designated above to be delivered to the shipping address listed on this form, ***I certify*** that I understand the above information. ***I represent and warrant*** that I am a licensed healthcare professional in good standing in the state referenced above and am authorized to write prescriptions and administer prescription drug products in the jurisdiction in which I am licensed. If I am a Nurse Practitioner or Physician Assistant, ***I certify*** that I am authorized and eligible in the state within which I am currently practicing to request and receive these samples, and that I have my supervising Physician's approval to do so.

I further certify that all information contained on this form is true and accurate as of the date signed below and that I understand that the obligations cited above are continuing obligations after receipt of the samples – to which I will adhere. All samples requests are subject to review and approval by Amgen Sample Accountability.

For Ohio licensed healthcare professionals: the Ohio Board of Pharmacy requires Terminal Distributors of Dangerous Drugs to obtain a TDDD license prior to accepting pharmaceutical drug samples or complimentary units, unless subject to the exemptions listed in ORC 4729.541. More information on Ohio's requirement can be found at http://www.pharmacy.ohio.gov/PrescriberTDDD. Therefore if you are an Ohio licensed healthcare professional who claims an exemption to the terminal distributor of dangerous drug licensing requirement, by checking the box below you attest that you meet one of the licensing exemptions under ORC 4729.541. Your signature on this sample request form serves as attestation and that you have the appropriate TDDD licensure or qualify under an exemption.

☐ Ohio TDDD Exemption (ORC 4729.541) or print TDDD License Number: _____

For Massachusetts licensed healthcare professionals: Massachusetts law recognizes as controlled substances those prescription drugs that are not federally scheduled (Schedule VI). Massachusetts law requires that practitioners who plan to manufacture, distribute, dispense, prescribe, administer, or possess controlled substances, including those prescription drugs that are not federally scheduled (Schedule VI), obtain a Massachusetts Controlled Substances registration. More information on Massachusetts's requirement can be found at https://www.mass.gov/orgs/massachusetts-controlled-substances-registration. Therefore if you are a Massachusetts licensed healthcare professional, your signature on this sample request form serves as attestation that you are aware of the obligation to maintain a MCSR to receive prescription drug products, including drug samples, and that you maintain a valid MCSR at the selected drug sample delivery address as required by law.

Signature: _____ **Date*:** _____

(Must Be Original Signature – No Stamped Signatures Accepted) (MM/DD/YYYY) *Required Field