

Requesting Physician Information

First Name: _____ Last Name: _____

Street Address: _____ Suite Number: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

D.E.A # _____ Rx License: _____

Please check box if samples are to be delivered to this address

Factor Provider Name

Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____

Please check box if samples are to be delivered to this address

Prescription Information

Medical record number: _____ Patient's weight: _____ kg or _____ lb

Dose: _____ IU/ dose Total requested: _____ IU

Patients are eligible for up to 3 total doses with a maximum of 12,000 IU.

Health Care Professional Certification

By signing below, I certify as follows:

1. That the therapy requested on this enrollment form is intended for a specific patient currently under my supervision and that it is medically necessary for said patient;
2. That I will not resell any product provided through this Grifol's AlphaNine[®] SD Sample Program to any third party;
3. That I will not bill any third party, including Medicare or Medicaid or any other federal healthcare program, for any product provided through this sample program;
4. That I understand that in accordance with government regulations, patients are not allowed to participate in this program if they are covered in whole or in part by any federal or state healthcare program, including but not limited to Medicare or Medicaid; and
5. That this patient, who is the sole recipient of this trial prescription, is not currently receiving therapy with AlphaNine[®] SD.

Physician Signature: _____ Date: _____
Print Name Signature

Fax completed form to Grifols Customer Service at 323.441.7968 for review and approval.

A9106-2-US-09

i For further information call: **Grifols USA, LLC** Professional Service: 888-GRIFOLS (888 474 3657)
Customer Service: 888 325 8579; Fax: 323 441 7968 www.grifols.com