INVEGA® SAMPLE REQUEST

INVEGA® PALIPERIDONE *Extended-Release Tablets* 1.5mg, 3mg, 6mg, 9mg

janssencns.com/invega

To receive samples of INVEGA®, just complete this form and return it by fax or mail.

Fax to:	*Mail To:* **INVEGA®**
1-844-203-4330	PO Box 6123, Lawrenceville, NJ 08648

4050068-SRF237

Deliver to:
(Fields with an * are required)

Date of Request:_____ **Void after 30 days**

***First Name:** ***Last Name:**

***State License Number:** ***Professional Designation :**

Practice Name:

***Address:** ***Suite/Floor/Building:**

(Cannot ship to a PO Box address)

***City:** ***State:** ***Zip:**

***Phone Number:** **Fax Number:**

***E-mail Address:**

By signing and submitting this form, you are requesting to receive samples of and information about INVEGA®. You understand that the information you provide will be used by Janssen Pharmaceuticals, Inc., its affiliates, and its service providers to fulfill your requests. The Privacy Policy available at www.invega.com/privacy-policy governs the use of the information you provide. You may call 1-800-JANSSEN for questions or concerns about the information you provide.

PLEASE CHECK THE ITEMS YOU WOULD LIKE TO RECEIVE. IF NONE ARE SELECTED, NO ITEMS WILL BE SHIPPED.

1

INVEGA® (paliperidone) Extended-Release Tablets

- ❑ **INVEGA® 3-mg Tablets,** 6 units, 7 tablets per unit
- ❑ **INVEGA® 6-mg Tablets**, 6 units, 7 tablets per unit
- ❑ **INVEGA® 9-mg Tablets,** 6 units, 7 tablets per unit

I certify that I am a licensed practitioner eligible to receive and prescribe these samples. 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 in states where required I have my supervising physician's approval to do so. Furthermore, I have requested these samples for the medical needs of my patients and I acknowledge that they are not for sale, resale, trade, barter, or to be returned for credit, or third-party reimbursement. I understand that either my signature or the signature of a responsible person at the receiving facility is required as a receipt of delivery. I also understand that my name and the sample distribution I receive may be reported as required by state or federal law and may then be made available to the public.

[State of Ohio only: By signing this document, I attest that by requesting shipment of these drug samples, I am in compliance with the State of Ohio ORC 4729.51 (TDDD license) or that the medical practice location meets one of the licensing exemptions as outlined in the regulation or in the addendum provided at the time of this request for samples.]

YOU MUST RESPOND IN THE SECTION BELOW.
Neglecting to respond will impact your ability to receive samples.

2

YES ❑ **NO** ❑ **Does the healthcare provider (HCP) treat or is he/she part of a treatment team caring for patients aged 18 or over with schizophrenia?**

YES ❑ **NO** ❑ **Does the HCP treat or is he/she part of a treatment team caring for patients aged 18 or over with schizoaffective disorder?**

SIGN HERE AND COMPLETE.

3

X _____

Licensed Practitioner's Signature (no signature stamps, please)	Professional Designation (MD, DO, NP, PA, or other)	State License # (if incorrect or missing above)	Date
MID-LEVELS ONLY:	Print Practice Specialty		Jurisdictional Requirements

Upon receipt of this request, samples will be shipped to you within 10 days.

Rules of this program are subject to change without notification.
For questions regarding this program or if you no longer wish to participate, please call 1-800-231-9339.
Authorized Distributor: J. Knipper and Company, Inc. Finished product manufactured by: Janssen Ortho, LLC, Gurabo, PR 00778

Please see full Prescribing Information, including Boxed Warning, attached.

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