Zoladex®
GOSERELIN ACETATE IMPLANT

Fax order form to:
1-800-396-2243

Order Form

Direct Purchase Program

Thank you for ordering from the ZOLADEX Direct Purchase Program. If you are a first time participant in this program, please complete both pages of this form and fax it to us at the number above.

If you are already a participating member of the Direct Purchase Program and are placing an order, simply fill out this first page only and fax it to us at the number above.

Step 1: Fill out required information

_ _ _ _ _ _ _ _ _ _ _ _/_ _

SLN number **SLN expiration**

_____

Account number (if you are already a participating member)

_____

First name

_____

Last name

(_ _ _) _ _ _ - _ _ _ _

Phone

_____

Office/Clinic name

Has your address changed? If YES, please provide updated information and select which address below:

☐ Billing Address ☐ Shipping Address ☐ Both Billing and Shipping Address

_____ _____ _____ _____

Address **City** **State** **Zip**

☐ Florida physician? Check box if you are NOT required to have a Health Care Clinic Establishment permit.

Step 2: Select dosage and fill out quantity

☐ **ZOLADEX 3.6 mg**
1-month depot – $220.20 per depot

☐ Fill in quantity

☐ **ZOLADEX 10.8 mg**
3-month depot – $660.60 per depot

☐ Fill in quantity

Please confirm your order is accurate before faxing this form. AstraZeneca does not accept returns.

FOR INTERNAL USE ONLY

Sales Representative (print name) _____

Audix Number and/or Phone _____

 3205714 Last Updated 1/16

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Agreement

Direct Purchase Program

This page to be completed <u>ONLY</u> with your first order to set up your account. If you already have an account set up, you do not need to complete this page.

On behalf of myself and the Practice, I/we understand and agree as follows: (1) that all purchases of ZOLADEX will be solely for the own use of my patients and/or patients of this Practice; (2) that reselling or redistributing ZOLADEX to any other entity or third party is expressly prohibited; (3) to fully comply with all applicable laws and regulations including the requirements of the Anti-Kickback Statute, Section 1128B(b) of the Social Security Act (42 U.S.C. §1320a-7b(b)) and other applicable federal and state fraud and abuse and anti-kickback laws; (4) that at no time shall the discounts offered by AstraZeneca hereunder exceed the floor for discounts mandated by the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990"), and (5) the terms of any invoice in respect of purchases of ZOLADEX hereunder are hereby incorporated herein by reference and made a part hereof.

Practice name

Your specialty

Physician name

_ _ _ _ _ _ _ _ _ _ **SLN number**

_ _/_ _ **SLN expiration**

E-mail address

Authorized Physician signature

☐ Yes, I would like to receive product and Web site updates from AstraZeneca.

Shipping address

Address

City State ZIP

(_ _ _) _ _ _ - _ _ _ _
Phone

Billing address

☐ Same as shipping address

Address

City State ZIP

(_ _ _) _ _ _ - _ _ _ _
Phone

Please list any other physicians in the Practice requesting their own "Ship To" account.

Additional physician

Physician name

_ _ _ _ _ _ _ _ _ _ **SLN number**

_ _/_ _ **SLN expiration**

E-mail address

Ship to address

Address

City State ZIP

(_ _ _) _ _ _ - _ _ _ _
Phone

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