



ARESTIN STUDENT ACCESS PROGRAM: ARESTIN Student Trial Kit Sample Request Form

Fax to: 888-553-6507 or email to: CS-QAreports@orapharma.com

You are completing this form because you have registered for the ARESTIN Student Access Program. In order to comply with the Prescription Drug Marketing Act of 1987, any school requesting samples of ARESTIN® (minocycline HCl) Microspheres, 1 mg, which are necessary to complete the program, must have a licensed dentist fill out this sample request form. As a participant in the ARESTIN Student Access Program, you will receive the samples of ARESTIN in the Student Trial Kit.

I certify that I am a licensed practitioner eligible to receive and prescribe these samples in the state within which I am currently practicing. Furthermore, I have requested these samples as part of the ARESTIN Student Access Program for the medical needs of patients, and I acknowledge that they are not for sale, resale, trade, or barter; or to be returned for credit or third-party reimbursement; or to be charged to patients.

The Student Trial Kit includes:

- 12 ARESTIN cartridges (NDC 65976-100-12) for clinical use
- Prescribing Information

The following information is required.

A copy of your current dental license must be included with this fax to facilitate the ARESTIN Student Sample Kit request for the ARESTIN Student Access Program.

DENTIST'S NAME _____

PROFESSIONAL TITLE _____ DDS / DMD (circle one)

SCHOOL NAME _____

SCHOOL ADDRESS _____

CITY/STATE/ZIP _____

PHONE # _____

NUMBER OF STUDENT TRIAL KITS REQUESTED _____ STATE DENTAL LICENSE # _____

DENTIST'S SIGNATURE _____ DATE _____
