
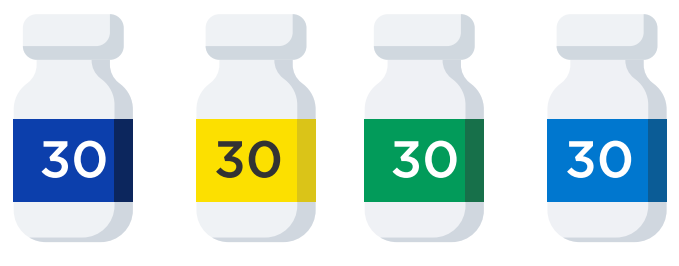
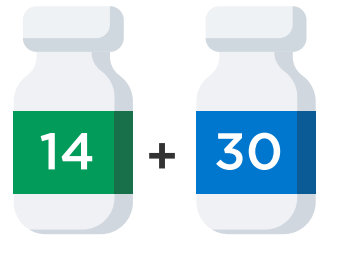


Product	Medication Offered	Supply	Price*
<b>New Patient Pack</b>	Qsymia 3.75 mg/23 mg Qsymia 7.5 mg/46 mg		<b>\$89</b>
<b>Strength</b>	Qsymia 3.75 mg/23 mg Qsymia 7.5 mg/46 mg Qsymia 11.25 mg/69 mg Qsymia 15 mg/92 mg		<b>\$89</b> <b>\$210</b> (free shipping for all 90-day prescriptions)
<b>Titration Pack</b>	Qsymia 11.25 mg/69 mg Qsymia 15 mg/92 mg		<b>\$98</b>

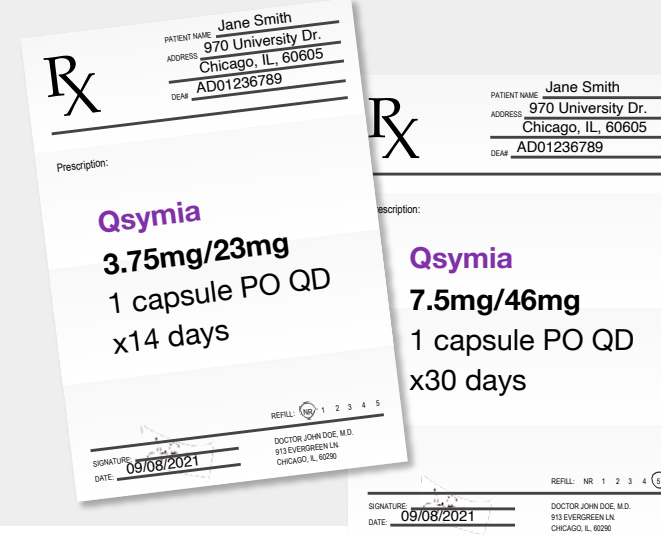
\*\$70 per month pricing applies to 90-day prescriptions only. Please note that 90-day prescriptions are not available in all states. \$89 home delivery pharmacy pricing includes 6-week New Patient Packs, 6-week Titration Packs and all 30-day prescriptions. For cash patients only. Insurance claims will not be processed. Additional shipping and handling costs will apply. There is a limit of one New Patient Pack and one Titration Pack per patient for the duration of the program. VIVUS LLC reserves the right to modify or discontinue these offers at any time without notice.

**Please fill out the following fields along with the embedded prescription for each dose prescribed for Qsymia.**  
Please submit prescriptions according to your specific state laws and regulations.

**1** **Licensed HCP:** \_\_\_\_\_ NPI: \_\_\_\_\_  
 DEA: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Email: \_\_\_\_\_ Fax: \_\_\_\_\_

**2** **PATIENT NAME:** \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Gender:  Male  Female  
 Email: \_\_\_\_\_

**3** **Rx EMBEDDED PRESCRIPTION**  
 Please complete prescription below and fax to:  
**844-678-8444**



**Please note:**  
 One prescription is required **for each dose**  
 within the New Patient and Titration Packs

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Instructions: \_\_\_\_\_  
 Quantity: \_\_\_\_\_  
 Refills: \_\_\_\_\_  
 Date Written: \_\_\_\_\_  
 HCP Signature: \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Instructions: \_\_\_\_\_  
 Quantity: \_\_\_\_\_  
 Refills: \_\_\_\_\_  
 Date Written: \_\_\_\_\_  
 HCP Signature: \_\_\_\_\_