ADASUVE™ REMS Program

WHOLESALER / DISTRIBUTOR ENROLLMENT FORM

adasuve
(loxapine) inhalation powder

Enrollment must be complete to distribute ADASUVE™. Please complete this form and:

Fax it to: 1-888-970-2301 or **Email it to:** ADASUVEdistribution@Alexza.com

WHOLESALER / DISTRIBUTOR AGREEMENT

I understand that ADASUVE™ is available only through the ADASUVE REMS Program and acknowledge that I must comply with the following program requirements:

- I will ensure that ADASUVE is only distributed to healthcare facilities in which enrollment in the ADASUVE REMS Program has been validated.
- I agree to cooperate with periodic audits or non-compliance investigations to ensure that ADASUVE is distributed in accordance with the program requirements.
- I understand I will be required to renew the wholesaler / distributor's enrollment in the ADASUVE REMS Program every three (3) years.
- I understand that this information may be shared with government agencies.

_____ _____

Wholesaler / Distributor Authorized Representative **Signature** Date

_____ _____

Wholesaler / Distributor Authorized Representative **(Print)** Title

WHOLESALER / DISTRIBUTOR INFORMATION

Wholesaler / Distributor Name: _____

Primary Ship to Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Fax: _____

AUTHORIZED REPRESENTATIVE INFORMATION

First Name: _____ Last Name: _____

Position / Title: _____

Phone: _____ Fax: _____

Email: _____ @ _____