

**PRESCRIBER COMPLETION OF LOTRONEX<sup>®</sup> REMS PROGRAM TRAINING FORM**

Thank you for completing the LOTRONEX REMS Program training. As a confirmation that you independently reviewed the provided training materials, please provide your details in the form below. Upon receipt you will be sent an acknowledgment notice.

*\* Required fields*

Prescriber's Information:

\*First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

\*Last Name: \_\_\_\_\_ Suffix (Sr, Jr, III...): \_\_\_\_\_

\*Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

\*NPI #: \_\_\_\_\_

Prescriber's Office Address:

\*Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ Zip code: \_\_\_\_\_

\*Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

\*E-mail: \_\_\_\_\_

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