

# Give this form to your doctor to obtain your free medicine.

## The Psoriasis Patient Medication Program:

- FREE 45 gm tube of Zithranol-RR™ for patients with mild-to-moderate stable plaque psoriasis
- Educational information and savings program

## About Zithranol-RR:

- Zithranol-RR is a non-steroid, topical prescription cream
- For more information about Zithranol-RR, visit the website [zithranol.com](http://zithranol.com)



**FOR PATIENT:** Hold the FREE medicine for:

Phone: \_\_\_\_\_

**FOR THE DOCTOR:** Professional Designation  
 MD  DO  PA  NP

Name: \_\_\_\_\_

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

City/State/ZIP \_\_\_\_\_

Office Phone: \_\_\_\_\_

Office Hours (Product sent via FedEx overnight requires a signature):

M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_

State License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

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

*I certify that I am a licensed practitioner eligible to receive and prescribe Zithranol-RR. If I am a Nurse Practitioner or Physician Assistant, I certify that I am authorized and eligible in the state within which I am currently practicing to request and receive Zithranol-RR and that I have my supervising physician's approval to do so. My signature on this request certifies that I recognize that this is for the needs of my patients and will not be sold, traded, bartered or returned for credit or for third-party reimbursement.*

Doctor, please fax completed form to:

**866-909-8677**