Fresenius Kabi USA, LLC

Three Corporate Drive
Lake Zurich, Illinois 60047
T 847-550-2300
T 888-391-6300
www.fresenius-kabi.com/us

Fresenius Kabi Product Replacement Attestation Form for Non-Specialty Pharmacy Provider

Email this form to productreplacement@fresenius-kabi.com within thirty (30) calendar days of the Product becoming unusable. Returned unusable Product must be received by Fresenius Kabi within thirty (30) calendar days of approval. Replacement Product generally ships within five (5) business days following receipt of returned unusable Product or receipt of Attestation that the product will be destroyed.

Provider Information

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

State License No.: _____

GLN/GPC Detail: _____

DEA No. or HIN: _____

Purchased Fresenius Kabi Product (the "Product"): _____

Amount of Product Rendered Unusable: _____

Provider Attestation

I declare that the information in this form is true and correct.

I am requesting replacement medication from Fresenius Kabi because the Product I purchased has been rendered unusable through unintentional, unplanned circumstances. Please check all that apply:

- ☐ I, or my staff, accidentally dropped, broke, or mishandled the Product.
- ☐ I, or my staff, accidentally stored the Product in a manner inconsistent with the Product storage instructions.
- ☐ The Product was destroyed or damaged by an Act of God (e.g., natural disaster).
- ☐ I, or my staff, accidentally made an error in mixing or reconstituting the Product.

I certify that I have not requested replacement product more than once in the last 12 months.

☐ I, or my staff, last requested replacement product on the following date: _____
OR
☐ I, or my staff, have not previously requested replacement product.

I certify that I, or my staff, have not administered any amount of the unusable Product to a patient. I also certify that the unusable Product was prescribed for an FDA-approved indication. I further certify that I, or my staff, have not sought payment or accepted reimbursement from any patient or third-party payor, including any state or federal entity or any private or other insurance plan, for the unusable Product, and that (please choose one):

☐ I will return the unusable Product to Fresenius Kabi.
OR
☐ I am unable to return the unusable Product to Fresenius Kabi and I will safely destroy the unusable Product and will complete the Verification of Destruction form provided by Fresenius Kabi prior to Fresenius Kabi shipping the replacement medication.

If Fresenius Kabi approves my request for replacement medication, I understand that (i) the replacement medication will be provided to me at no charge, (ii) there is no purchase requirement associated with my receipt of the replacement medication, (iii) the replacement medication is not intended as a reward or inducement for any referrals, and (iv) I may not resell or transfer the replacement medication to any other individual or entity for any purpose.

Provider Signature: _____

Date: _____

Print Name: _____