To receive your complimentary samples of

VIIBRYD® (vilazodone HCI)

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Your shipment of professional s	samples may only be sent to your office address.					
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	MI	D	DO	NP	PA	CNP
Practitioner/Physician name	Professional designation (check one)					
Phone number	Email	l addres	S			
Address (Samples will not be	issued or delivered to a PO Box; please provide your office ac	dress.)				
City	State	ZIP c	ode			
State license number			Exp	iration date		
Product request:	Product description:			NDC #:		
(Please Check) 12 Patient Sample Packs	VIIBRYD® (vilazodone HCI) Tablets 2-week Patient Sample Pack (each pack includes 7 [seven] 10 mg t 7 [seven] 20 mg tablets)	ablets ar	nd	0456-1101	-14	
5 Bottles	VIIBRYD® (vilazodone HCI) 40 mg tablets (each bottle includes 7 [seven] 40 mg tablets)			0456-1140	-07	
By signing and returning this form, I ackno complimentary samples of the above item	owledge that I am currently licensed with the appropriate state and federal authoritie. s.	's to receive	e this product	and would like Al	bbVie to provi	de me with
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