COLORADO EPINEPHRINE AUTO-INJECTOR AFFORDABILITY PROGAM REPLACEMENT PRODUCT REQUEST FORM

Please complete the form below and return it to Teva Customer Service
by FAX (800-760-1009) or Email to: TevaCS@TevaPharm.com

Pharmacy Business Name:			
Pharmacy Street Address: (Must match State license)			
City:		State:	
Zip Code	Pharmacy GLN:		Date of Request:
Contact Name:		Phone No.	
Pharmacy State License#		Expiration Date	
Email Address:			
Patient Initials:			DOB:

Select replacement NDC below:

00093-5985-27	EPINEPHRINE INJECTION SYRINGES 0.15MG 2	☐
00093-5986-27	EPINEPHRINE INJECTION SYRINGES 0.3MG 2	☐

One replacement pack containing 2 units per patient / order form will be shipped.
Please allow 5-10 business days for product shipment.

By signing below, I affirm, to the best of my knowledge and belief, that (1) the information provided above is true and accurate, (2) the patient holds a valid prescription for epinephrine auto-injectors, has submitted the required Epinephrine Auto-Injection Affordability Program Application to the pharmacy, and is an "eligible individual" as defined by Colorado HB23-1002, and (3) this request meets the requirements of – and is otherwise in compliance with – Colorado HB23-1002.

Print Name	Title
Signature	Date

Please attach a PDF of your physical State Board of Pharmacy License. We cannot accept screenshots of the State Board Pharmacy website or online license verifications. Teva reserves it right to request additional information to evaluate this request, and its compliance with Colorado HB23-1002.

Form Date: 2/24