

**LEVULAN[®]
KERASTICK[®]**

(aminolevulinic acid HCl)
for Topical Solution, 20%



BLU-U[®]

Blue Light Photodynamic Therapy
Illuminator Model 4170

LEVULAN[®] KERASTICK[®] (aminolevulinic acid HCl) for topical solution, 20%

ORDER FORM

Step 1: Please download/save this form to your desktop.

Step 2: Open the form in Adobe Acrobat, or your PDF reader application.

Step 3: Fill out the form electronically and save.

Step 4: Email the completed form to [**cs-inbox@sunpharma.com**](mailto:cs-inbox@sunpharma.com)

Please Note:

You must sign and date the form in order for the order to be processed.

If you are paying via credit card, please FAX your order to: 1-877-909-3872,
or call 877-533-3872 x5 x4. We do not accept credit card information via email.

D U S A[®]
a SUN PHARMA company

25 Upton Drive
Wilmington, MA 01887
[**www.LevulanHCP.com**](http://www.LevulanHCP.com)


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DERMATOLOGY



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Wilmington, MA 01887
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Email: cs-inbox@sunpharma.com
Phone: 1-877-533-3872 x5 x4

ORDER FORM LEVULAN® KERASTICK® (aminolevulinic acid HCl) for topical solution, 20%

PHYSICIAN INFORMATION:

Shipping ID#: _____ Billing ID# _____

Office Name: _____

Licensed Practitioner Name: _____

State License Number: _____

Delivery Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email Address: _____

Billing Address (If Different): _____

City: _____ State: _____ ZIP: _____

PRODUCT TO BE ORDERED:

Item Name	Quantity Requested (Number of Boxes)	Price Per Box	Total
Box of Levulan Kerastick			
Box of Patient Goggles (4 per box)			
Box of Clinician Glasses (2 per			
PLEASE NOTE: There is a 24-Hour processing time for all orders. If delivery is not selected, our standard shipping will default*		Delivery Charge*	
		Total Amount	

DELIVERY CHARGES

- UPS Ground: \$9.50
- FedEx 2nd Day (Standard) \$14.50*
- FedEx Overnight (Expedited) \$24.50

PAYMENT INFORMATION:

- Net 30 Net 90
- PO# _____
- Credit Card
(SEE ATTACHED FORM)

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge.

Physician Print Name: _____

Physician Signature: _____ Date: _____

Order Placed By (Please Print): _____

Signature: _____ Date: _____

Thank you for your order! Drug product is not returnable unless received damaged.

Please save damaged product and contact ProPharma at 877-533-3872 x5 x1 for return instructions

25 Upton Drive
Wilmington, MA 01887
www.LevulanHCP.com

Fax to: 1-877-909-3872
Phone: 1-877-533-3872 x5 x4

CREDIT CARD FORM LEVULAN[®] KERASTICK[®] (aminolevulinic acid HCl) for topical solution, 20%

We do not accept credit card information via email, please FAX in order form or call 877-533-3872 x5 x4 to place orders.

CREDIT CARD INFORMATION:

Card Type (Please Circle): AMEX Discover MasterCard VISA

Cardholder: _____

Card #: _____

Exp. Date: _____ CSV Code: _____

Credit Card Billing Address: _____

City: _____ State: _____ ZIP: _____

Billing Contact: _____

