



XATMEP™

(methotrexate) Oral solution

Product Order Form

To reach the Anovo Xatmep team, call 844-288-5007, Option 3

Please submit this order form by email or fax.

E: Wholesale@AnovoRx.com F: 866-927-2048

Thank you for your order. Please review this important information.

- Orders placed after 3 p.m. CST will be processed the following business day.
- Orders will be shipped to the address on your facility license.
- Shipments are scheduled Monday - Thursday for arrival Tuesday - Friday. Delivery service may be upgraded or provided on holidays, Saturday, Sunday, or outside the 50 United States, at customer's request and for an additional charge determined in advance by AnovoRx Distribution, LLC (Anovo).
- Please inspect product carefully upon receipt. All claims of incorrect, damaged, contaminated, mislabeled or misbranded merchandise must be made to Anovo via email at wholesale@AnovoRx.com within two (2) business days of receipt of product.
- Returns are pursuant to this Anovo return policy: Anovo assumes no responsibility or liability for loss or damage by reason of delay or inability to ship for any reason. Anovo does not accept product for return unless damaged or defective when received by customer from Anovo.
- Payment is due and payable in full within 30 days of receipt of invoice. Pricing is determined at the time Anovo receives the purchase order.
- Anovo will not recognize, accept or honor any prompt-pay or other discounts taken by customer or its agents.
- There are no shipping/handling fees for orders. Risk of loss of the goods shall pass to customer upon tender of the goods to customer.

For purchases made other than under the federal government's FSS program: All product is sold pursuant to the Anovo Wholesale or Network Wholesale Agreement, and the terms and conditions set forth therein. In no event shall any of the terms or conditions of any purchase order submitted by customer be binding on Anovo other than to identify the goods ordered, the quantity ordered and the ship-to location.

All fields on this form must be completed to avoid delays in processing and shipping your order.

Drug Name	NDC	Container	Quantity
Xatmep™ (methotrexate) Oral solution	52652-2001-1	BOTTLE	
ACCOUNT NUMBER:			
CUSTOMER NAME:			
Purchase Order Number:			
Purchasing Agent Name:		Purchasing Agent Title:	
Purchasing Agent Phone:		Purchasing Agent Email:	
Billing Address:		Billing City, State, Zip Code:	
Billing Contact Phone:		Billing Contact Email:	
Is this order FSS eligible:	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes:	<input type="checkbox"/> VA <input type="checkbox"/> DOD <input type="checkbox"/> IHS <input type="checkbox"/> Other: _____
Is this order 340B eligible?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, 340B ID is required:			
If 340B, Name of Covered Entity required:			
Comments:			
Anovo employee signature required if order taken by phone: _____			