**Transfer callers with a Reportable Safety Event or Medical Information Request:**

**All other US Branded Products to 1-888-483-8279**

**All US Generic products to 888-838-2872, Press 9 for direct contact**

**Transfer callers with a Product Complaint to Quality Assurance Services (QAS):**

**For all Teva Products, transfer to 888-838-2872 option #3 and then option #3**

**For Adverse Events, Product Complaints, and/or Medical Information inquiries that are not transferred to Teva or that are received in writing, complete this form with as much information as possible.**

**For Adverse Events and Product Complaints send the completed form to the appropriate department within one business day. For forms with multiple “report types”, forward completed form to each department respectively.**

**For ${company\_name} and other written complaints, please forward:**

**Medical Information questions to** [**USMedInfo@tevapharm.com**](mailto:USMedInfo@tevapharm.com) **or Fax to 703-657-2912**

**All Safety Reports to** [**drug.safety@tevapharm.com**](mailto:drug.safety@tevapharm.com) **or Fax to 973-358-4570**

**Product Complaint Reports to** [**QAS@tevapharm.com**](mailto:QAS@tevapharm.com) **only if unable to call the QAS number (888-838-2872 is preferred)**

Type of Report: X Adverse Event  Product Complaint  Medical Information Request  Patient Assistance   
 Program

Other Reportable Event (Death, Overdose/accidental exposure/medication error, Misuse/abuse, Diversion,

Pregnancy/infant exposure during breastfeeding, Lack of efficacy, Transmission of infectious agent via product)

Vendor / Program /Project Information

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor /Project /Program | X | Tracking/Reference No. |  |
| Date / Time Received  MM / DD / YYYY | X | Received by |  |
| Date / Time sent to Teva  MM / DD / YYYY | X | Sent via Email / Fax |  |
| Was Form also sent to QAS ? (Yes/ No) |  | Was Form also sent to Medical Information ? (Yes /No) |  |

Product Details:

|  |  |
| --- | --- |
| Product | X |
| Indication | X |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Strength |  | Dosage |  | Frequency |  |
| Start Date  **MM / DD / YYYY** |  | Stop Date  **MM / DD / YYYY** |  | NDC # |  |
| Lot/Batch |  | Exp Date |  | Product Quality Issue (Yes / No) |  |

How was the report/request received?

Inbound Call  Outbound Call  In writing (i.e., e-mail, letter, fax, etc.)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Patient Assistance Program Queries:

Was Contact/Query regarding an Enrolled Patient  Yes  No

Was Contact/Query to request discontinuation of drug shipments for an enrolled patient who is now deceased  Yes  No

Continue on Page 2

## Reporter Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Qualification (Patient /HCP / Family / Other) | | X | | | | |
| First name | ${company\_name} | Last name | | ${newScreen\_7.User\_Name} | | |
| Fax number |  | Phone number | |  | | |
| Email |  | | | | | |
| Street Address | X | | | | | |
| City | X | | State | X | Zip code | X |
| Can Teva contact the reporter(Yes/ No) | | |  |

**Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | X | Last name | X |
| Sex | X | Initials | X |
| Age |  | DOB  **MM / DD / YYYY** |  |

**Health Care Professional Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Physician or HCP title | |  | | | |
| First name |  | Last name |  | | |
| Fax number |  | Phone number |  | | |
| Email |  | | | | |
| Street Address |  | | | | |
| City |  | State |  | Zip code |  |
| Can Teva contact the HCP ? (Yes/ No) | |  |

Detailed Description of Adverse Event/other Reportable Event, Product Complaint or Medical Information Request:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Adverse Event Treatment(s):** Detailed Description of Treatments patient received for the recorded Adverse Event(s), please include date (MM/DD/YYYY) if applicable

${first\_name}\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Product available for return:** Yes  No Unknown

**Did the product complaint cause any adverse health consequences?** Yes N**o**Unknown

Continue on Page 3

**For Adverse Event Report, please complete the following information, if available:  
  
Concomitant Medication(s):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Medication | Indication | Start Date  (MM / DD / YYYYY) |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

**Medical History/Concurrent Illnesses/Allergies:**

|  |  |  |
| --- | --- | --- |
|  | **List of Medical History** | **Start Date (MM / DD / YYYYY)** |
| **1** |  |  |
| **2** |  |  |
| **3** |  |  |
| **4** |  |  |
| **5** |  |  |

**Relevant Labs/Diagnostic Procedure(s):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **List of Relevant Labs** | **Value / Result** | **Date**  **(MM / DD / YYYYY)** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |