KANE BIOTECH

CLINICAL EVALUATION AGREEMENT FORM
revyve® Antimicrobial Wound Gel

Document No.	Document Title	Revision	Eff Date
DOC-4271	**revyve® AWG Clinical Evaluation Agreement Form**	**1**	**01/22/26**

Date: _____ revyve® Representative: _____
Practice Name: _____ HCP Name: _____

Practice Street (incl. Bldg Suite): _____

City: _____ State: _____ Zip: _____

SKU	Description	Quantity
FG2001RX-US	revyve® Antimicrobial Wound Gel – 1 oz	24

Description of program: A maximum of 3 patients will be identified and simultaneously followed for (4) consecutive weeks with revyve® Antimicrobial Wound Gel (revyve®) applied one to two times per week. In exchange for offering revyve® 1 oz, at no charge, we are requiring documented clinical feedback to be completed on the Patient Clinical Evaluation Form. In compliance with regulatory requirements, revyve® is being provided at no charge to a Healthcare Provider (HCP) as a clinical evaluation product if the HCP is unfamiliar with the product.

Agreement: I understand that this product is being provided to me/my facility to enable me/us to assess the appropriate use and functionality of the product and determine whether and when to use, order, purchase, or recommend the product in the future. I agree to use the product in a manner consistent with the approved uses indicated in the labeling of the product. Further, I understand the product is being provided to me/us by the Company at no charge and I agree to accurately represent the no charge status of this product when seeking reimbursements for patients, their primary or secondary insurance carriers, or any state or federal healthcare programs.

By submitting this form, I certify that the provisions of the product at no charge are strictly for evaluation purposes.

Patient #1 Identifier: _____ Patient #2 Identifier: _____
(Do not use PHI)

HCP Signature: _____ NPI #: _____ Date: _____

Approved By Kane Biotech VP of Business Development: _____ Date: _____

Please email CEP form to hcp@kanebiotech.com