

SAMPLE REQUEST FORM (SRF-XIII)

Yes! Please send me **information and patient starter** samples of IQUIX[®] and BETIMOL[®] as indicated below.

"I certify that I am a licensed practitioner eligible to receive and prescribe these samples. These samples are for the medical needs of my patients. I acknowledge that they are not for sale, resale, trade, barter, to be returned for credit or for third party reimbursement. Sample information listed below is correct and upon receipt of the samples, I agree to sign, date and return the required Acknowledgement of Delivery. I understand that only valid, signed and dated Sample Requests will be processed."

Licensed Practitioner's ORIGINAL Signature ONLY

Month/Day/Year



Your Free Sample Package will contain
6 bottles of 1.0 mL IQUIX 1.5%
(NDC # 68669-145-99)

Yes, please order this product:
(Please check box for IQUIX)



Your Free Sample Package will contain
6 bottles of 2.5 mL BETIMOL 0.5%
(NDC # 68669-525-99)

Yes, please order this product:
(Please check box for Betimol)

PLEASE COMPLETE ALL FIELDS BELOW:

Practitioner Name: _____
State License #: _____
TPA (Optometry): _____
Address: _____
City: _____
Phone #: _____
Sample Request Date: _____

Professional Designation: _____ Specialty: _____
Expiration Date: _____
State: _____ Zip: _____
Email: _____
Fax #: _____

"One Time Use Only - Do Not Refax"

Please fax this form to 732-901-2008 or mail to:
VISTAKON[®] PHARMACEUTICALS, LLC
P.O. Box 2101
Lakewood, NJ 08701-9750

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Please see full prescribing information for IQUIX[®] and BETIMOL[®] available on the websites.