

SAMPLE REQUEST FORM (SRF-XX)

Yes! Please send me **information and patient starter** samples of IQUIX[®], BETIMOL[®], or ALAMAST[®] 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

IQUIX[®]
(levofloxacin ophthalmic solution) 1.5%

BETIMOL[®]
(TIMOLOL OPHTHALMIC SOLUTION)
0.25%, 0.5%

Alamast[®]
(pemirolast potassium ophthalmic solution) 0.1%

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

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

Your Free Sample Package will contain 4 bottles of 2.5 mL ALAMAST 0.1% (NDC # 68669-711-98)

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

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

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




PLEASE COMPLETE ALL FIELDS BELOW:

Practitioner Name: _____ Professional Designation: _____ Specialty: _____
State License #: _____ Expiration Date: _____
TPA (Optometry): _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Email: _____
Sample Request Date: _____ 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

VISTAKON[®] PHARMACEUTICALS, LLC

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Manufactured by Santen Oy, Tampere, Finland 
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Please see full prescribing information for IQUIX[®], BETIMOL[®], and ALAMAST[®], available on the websites.