Sample Request Form

Complete form and email or fax this form to Beach Sample Order Fulfillment:

Email: sampling@beachpharma.com Fax: 813.839.4665 Phone: 813.839.6565

Please Note: In compliance with the Prescription Drug Marketing Act regulations, incomplete request forms cannot be processed and supplies will not be forwarded.

Practitioner Designation: ❑ MD ❑ DO ❑ NP* ❑ PA* ❑ OTHER _____

Practitioner First Name_____ Last Name _____

Address _____
(Samples will not be delivered to a PO Box; please provide your office address)

City_____ State_____ ZIP_____

Phone_____ Fax_____

State License #_____ Expiration Date _____

BEACH PHARMA. reserves the right to decline requests for samples from practitioners whose medical practice and/or patient population is deemed inconsistent with the approved product indication(s).

Beach Pharmaceuticals Products (Please Select Below):

❑ Beelith- Magnesium Oxide/ Pyridoxine HCL 362mg/25mg 26 tablets (4 bottles)
NDC# 00486113226

❑ K Phos #2- Sodium Phosphate Monobasic/ Potassium Phosphate monobasic 305mg/700mg 26 tablets (4 bottles)
NDC# 00486113426

❑ K Phos Original- Potassium Phosphate Monobasic 500mg 50 tablets (4 bottles)
NDC# 00486111150

❑ K Phos Neutral- Sodium Phosphate Dibasic/ Potassium Phosphate Monobasic/ Sodium Phosphate Monobasic 852mg/155mg/130mg 26 tablets (4 bottles)
NDC# 00486112526

I understand that BEACH PHARMA. is providing professional samples free of charge as indicated above. I certify that I am a licensed practitioner eligible to request, receive, prescribe and dispense these samples. I have requested these samples for the medical needs of my patients and I will not sell, resell, trade, barter or return them for credit. Additionally, by signing below, I certify that I will not seek payment or reimbursement from any patient, third part payer (including but not limited to Medicare or Medicaid) or other entry for any professional sample(s) I may receive free of charge as a result of this request. *If I am a Nurse Practitioner or Physician Assistant, I certify I am authorized and eligible, in the state in which I am now practicing, to request and receive these samples and I have my supervising Physician's approval to do so (if applicable).

SIGN HERE _____ ___/___/___
Practitioner Signature (no signature stamps, please) Date

_____ _____
Practitioner Name Professional Designation

Orders are processed and shipped to arrive to your site within five (5) business days following our receipt of a ***complete and valid*** sample request form. We do not ship product Friday through Sunday.

MANDATORY SUBSECTION FOR ALL OHIO BASED HCPs:

Under Ohio law, BEACH PHARMA. may only provide drug samples to prescriber's whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exemptfrom such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity, including prescriber practices, to receive, purchase, and possess prescription drugs and controlled substances, including drug samples, for distribution to patients. Not all prescriber practices, however, are required to obtain a TDDD license. For example, subject to certain exceptions, an individual prescriber doing business as a sole proprietor (not incorporated in any manner) or a practice that is a corporation, limited liability company, or professional association where a prescriber is the sole shareholder and is authorized to provide the professional services being offered by the practice are exempt from obtaining a TDDD license. For a complete list of exemptions, please refer to section 4729.541 of the ORC. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at www.pharmacy.ohio.gov/PrescriberTDDD. The above information is being provided for your convenience and is not offered as, nor should it be construed as, legal advice.

Please select and complete one of the following:

❑ The practice at which I work, **[insert name]**_____, located at the address I provided above, has an active TDDD license that allows me to receive and store the requested samples at this location. The TDDD license number is_____ and expires on_____.

❑ I attest that I am claiming exemption to the TDDD licensing requirement per ORD 4729.541 and the Ohio Terminal Distributor Licensing of Prescriber Practices guidance document.

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested samples at the address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

SIGN HERE _____ ___/___/___
HCP must sign and date. Stamped signature not accepted. Date