# Sample Request
## Fax Form

To receive your complimentary samples of
**DELZICOL® (mesalamine) delayed-release capsules,**
complete this form and fax it to:

**DELZICOL® Sample Order Fulfillment**
**FAX #: 1.877.477.1258**

Delzicol®
(mesalamine) 400 mg
delayed-release capsules

***Visit ALLERGANACCESS.com to view Allergan savings programs and brand support resources. No login required.***

Your shipment of professional samples may only be sent to your office address.

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

| Practitioner name | Professional designation (circle one)<br>MD DO NP PA |
|---|---|
| Phone number | Fax number |
| Address **(Samples will not be issued or delivered to a PO Box; please provide your office address.)** | |
| City / State / ZIP code | |

| Product request<br>(Please check one) | Product description | NDC |
|---|---|---|
| ☐ **6 bottles**<br>☐ **12 bottles** | **DELZICOL® (mesalamine) delayed-release capsules containing four 100 mg tablets**<br>(each bottle contains 12 [twelve] capsules) | **NDC 0023-5853-12**<br>Manufacturer: Warner Chilcott Deutschland GmbH<br>Authorized sample distributor:<br>J. Knipper and Company, Inc. |

***There is a maximum fulfillment of one request per month per prescriber.***

By signing this form I request the drug samples listed herein and certify that I am a licensed practitioner currently authorized under applicable federal and state law to request, receive, and dispense these drug samples. I also certify that I have requested these samples for the legitimate medical needs of my patients. I understand that the sale or offer to sell a drug sample is a federal offense. I certify that I will not seek payment from any patient or third-party payor for these drug samples and I will not sell, resell, trade, barter, return for credit, or seek reimbursement for any drug sample.

Allergan 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).

| Practitioner/Physician signature | Date |
|---|---|
| State license number | Expiration date |

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