



SOMA® (carisoprodol) 250 mg Tablets SAMPLE FAX ORDER FORM

Please provide me with:

_____ 1 sleeve of SOMA® 250 mg (Contains 10 – one day 4 tablet complimentary sample)

SHIPPING INFORMATION (Shipping method is 2nd Day Air):

Date: _____

Ship-To Address (Please be sure to complete all fields below.):

First Name: _____ (required) Last Name: _____ (required)

Professional Designation: _____ (required) State License #: _____ (required)

Physician's Specialty _____ (required) DEA#: _____ (required, address must coincide with ship to address)

Street Address: _____ (required) NO PO Boxes

Bldg/Ste/Floor#: _____ (required)

City: _____ (required) State: _____ (required) Zip code: _____ (required)

Phone #: _____ (required) FAX #: _____ (required)

E-Mail Address _____ (required)

I would like to receive additional e-mail sample forms, information and/or offers regarding Meda Pharmaceuticals products.

Practitioner's Signature: _____ (required) (must be original signature not a stamp)

My signature verifies that I have requested the prescription samples indicated on this form. I certify that the State License Number printed on this document is my correct, active number. If I am a mid-level practitioner, and it is required by the state indicated on this form, I certify that I have the appropriate, active collaborative agreement in place.

THIS FORM MUST BE FAXED TO 800 868 2690

This section to be filled out by Home Office

Authorized By: _____ Date: _____

Date Request Processed: _____ Processed By: _____