



# PALGIC<sup>®</sup>

## CARBINOXAMINE MALEATE

### Sample Request Form

**Palgic<sup>®</sup> is a histamine H<sub>1</sub> receptor blocking agent indicated for the symptomatic treatment of:**

- Seasonal Allergic Rhinitis
- Urticaria
- Adjunctive therapy for anaphylactic reactions (to Epinephrine)
- Perennial Allergic Rhinitis
- Angioedema
- Vasomotor Rhinitis
- Allergic Conjunctivitis
- Dermatographism
- Amelioration of the severity of allergic reactions to blood or plasma

**Each Palgic<sup>®</sup> tablet contains 4mg of carbinoxamine maleate.**

Name \_\_\_\_\_ Title \_\_\_\_\_ Specialty \_\_\_\_\_

Office Street Address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Contact \_\_\_\_\_ Extension \_\_\_\_\_

Office Phone \_\_\_\_\_ Ext \_\_\_\_\_ Fax Number \_\_\_\_\_

Email \_\_\_\_\_ will be solely used by PamLab LLC for contact regarding your sample requests and for invitations and special offers related to your specialty. We use a secure email server.

State License # \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Required for Samples*

DEA # \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Required for Samples*

**Please stock the following pharmacies with Palgic<sup>®</sup>**

Pharmacy Name	Address	City	State	Phone #
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Please send the following samples for the use of the medical needs of my patients from PamLab L.L.C. I certify that I am a licensed practitioner eligible to receive these samples under applicable law, and that my state license is valid and current.

**4mg tablet product samples**

Signature of Above \_\_\_\_\_  
Licensed professional \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**08/27/08 Website**

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