



## BRUKINSA Physician Sample Request Form

Order Date:

Hours of Operation (for Receiving):

Physician First Name: **(required)**

Physician Last Name: **(required)**

Delivery Address: **(required)**

City: **(required)**

Province: **(required)**

Postal Code: **(required)**

Telephone #: **(required)**

E-Mail(for confirmation of shipment): **(required)**

Product Name	Product Number	DIN #	Quantity
Brukinsa 80mg 120 ct caps	SKU Innomar	02512963	Check one: <input type="checkbox"/> 1 <input type="checkbox"/> 2

Physician Signature: **(required)**

Physician License #: **(required)**

Click 'Fill and Sign' to complete the form, click  
'Sign Yourself' to sign electronically, save and email to  
[samples@beigene.com](mailto:samples@beigene.com)

\* If you are not able to sign the document electronically please print the form  
to sign and email to [samples@beigene.com](mailto:samples@beigene.com)