connective Rx

Patient Mail-Order Reimbursement Form

If you have paid your copay in full in the last 90 days, you may be eligible for reimbursement of certain product-specific copay, co-insurance or deductible costs directly and actually incurred for a prescription for Tirosint® (levothyroxine sodium) capsules under the Tirosint Copay Card Program. Reimbursement is subject to program terms and conditions. Payment of the reimbursement is also subject to verification. Submission of this form is not a guarantee of payment.

To receive reimbursement within 4 weeks for a valid prescription claim, please take the following steps:

1. Complete this form
2. Mail this form and the original pharmacy receipt to:
   Tirosint Offer
   PO Box 2355 Morristown, NJ 07962

The original pharmacy receipt should include:

1. Patient Name and Address
2. Pharmacy Name, Address and Phone Number
3. Prescription #, Fill Date, Drug Name, Strength, NDC #, and Quantity
4. Amount of your out-of-pocket payment

First Name: ____________________

Last Name: ____________________

Date of Birth (MM/DD/YYYY): ____________________

Street Address: ____________________

City: ____________ State: ________ Zip: ________

Phone #: (_____) - ______ - ________

Group # (on your Tirosint card): ____________________

ID # (on your Tirosint card): ____________________

Are you privately insured? ❑ Yes ❑ No

Name of the insurer: ____________________

BIN # ____________ PCN # ____________

Drug Name: ____________________

Drug Strength: ____________________

For qualified patients only. Not valid for prescriptions eligible to be reimbursed under Medicare (including Medicare Part D and Medicare Advantage), Medicaid, TRICARE™, CHAMPUS, the Puerto Rico Governmental Health Insurance Plan, or other federal, state, or governmental healthcare programs. See program rules and eligibility requirements.

I, ______________________________, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the product-specific copay, co-insurance, or deductible expenses requested for reimbursement were actually incurred. My prescription for Tirosint was not paid in whole or in part by Medicare, Medicaid, VA, DOD, TRICARE, CHAMPUS, the Puerto Rico Governmental Health Insurance Plan, or any federal or state programs including any state pharmaceutical assistance program. This program is not valid where prohibited by law, taxed or restricted. Limitations may apply to Massachusetts and California residents.

Patient Signature ______________________________

If you have questions about the Tirosint Copay Card or you wish to discontinue your participation, please contact us at 1-833-666-2501, 24 hours a day, 7 days a week

IBSA Pharma Inc., 8 Campus Drive, Suite 201, Parsippany, NJ 07054
© 2018 IBSA Pharma Inc. All rights reserved. PM-00-18-0012

See next page for Terms and Conditions.

connectiveRx

Terms and Conditions

This program only applies to patients who are at least 18 years of age, residents of the 50 United States, the District of Columbia, and Puerto Rico, are prescribed Tirosint® (levothyroxine sodium) capsules for an FDA-approved indication, and are insured and covered by a commercial health plan. This offer is not valid for prescriptions covered by or submitted for reimbursement under Medicaid, Medicare, VA, DOD, TRICARE, CHAMPUS, the Puerto Rico Governmental Health Insurance Plan, or similar federal or state programs including any state pharmaceutical assistance program. It is not an insurance benefit, and does not cover or provide support for supplies, procedures, or any physician-related services associated with Tirosint. General, non-product specific insurance deductibles above the amount set forth above are also not covered. IBSA reserves the right to rescind, revoke, terminate, or amend this offer, eligibility, and terms and conditions at any time without notice. Patients, pharmacists, and prescribers cannot seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this offer. This offer is not conditioned on any past, present or future purchase, including refills. The copay card is non-transferable, limited to one per person, and cannot be combined with any other offer or discount. This program is not valid where prohibited by law, taxed or restricted. Limitations may apply to Massachusetts and California residents. Offer has no cash value.

Patient Instructions: Tirosint must be covered by your commercial insurance. Program is not valid for cash paying customers. If your prescription is covered by insurance, you may need to notify the insurance carrier of redemption of this copay card. This offer is not valid for prescriptions covered by or submitted for reimbursement under Medicaid, Medicare, VA, DOD, TRICARE, CHAMPUS, the Puerto Rico Governmental Health Insurance Plan, or similar federal or state programs including any state pharmaceutical assistance program. This Card is not valid where prohibited by law.Limitations may apply to Massachusetts and California residents. By redeeming using this Card, you are certifying that (1) you are not a beneficiary of any government funded program as noted above; (2) should you begin receiving prescription benefits from any government funded program, you will withdraw from this program; and (3) you acknowledge and understand that adherence to the terms and conditions of this offer is necessary to ensure compliance with laws pertaining to any government funded program. For questions regarding your eligibility or benefits or if you wish to discontinue your participation, please call 1-833-666-2501.

Pharmacist: When you process this card, you are certifying that you have read, understood, and are in compliance with the terms and conditions pertaining to this program. You are further certifying that you have not submitted and will not submit a claim for reimbursement under Medicaid, Medicare, VA, DOD, TRICARE, CHAMPUS, the Puerto Rico Governmental Health Insurance Plan,or similar federal or state programs including any state medical pharmaceutical assistance program for this prescription.

© 2018 IBSA Pharma Inc. All rights reserved. PM-00-18-0012