

Here is your Androderm® Savings Card

Your card is now ready for use. Present this page with a valid Androderm® prescription to your pharmacist.

ELIGIBLE PATIENTS

PAY \$45
THEN **SAVE UP TO \$75**
PER 30-/60-DAY PRESCRIPTION FILL

PAY \$45
THEN **SAVE UP TO \$150**
PER 90-DAY PRESCRIPTION FILL

Powered by: **CHANGE HEALTHCARE**

BIN# 004682
PCN# CN
GRP# EC51027001
ID# 09016841433

ANDRODERM III
(testosterone transdermal system)

Eligible patients may pay \$45 for a 30-day supply for each of up to twelve (12) prescription fills OR for a 90-day supply for each of up to four (4) prescription fills.

Prescriber ID# required on prescription. This offer is not valid for prescriptions covered by or submitted for reimbursement under Medicaid, Medicare, or similar federal or state programs (including any state medical pharmaceutical assistance program), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. This offer is not valid for those under 18 years of age. Valid for patients with commercial insurance only. Offer valid for up to 12 uses (30-day supply fill, up to six (6) uses (60-day supply fill)) OR 4 uses (90-day supply fill). This is not insurance.

Patient Instructions: Program Terms, Conditions, and Eligibility Criteria: **1.** This offer is valid only for patients 18 years of age or older and is good for use only with a valid prescription for Androderm® (testosterone transdermal system) at the time the prescription is filled by the pharmacist and dispensed to the patient. **2.** Depending on insurance coverage, most eligible patients may pay \$45 then save up to \$75 per 30-day or 60-day supply, or up to \$150 per 90-day supply of Androderm. Check with your pharmacist for your savings. Maximum savings limit applies; patient out-of-pocket expense may vary. **3.** This offer is not valid for use by patients enrolled in Medicare, Medicaid, or other federal or state programs (including any state pharmaceutical assistance programs), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this offer if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. This offer is not valid for cash-paying patients. **4.** This card is valid for up to twelve (12) prescription fills for a 30-day supply, up to six (6) prescription fills for a 60-day supply, or for up to four (4) prescription fills for a 90-day supply. Offer applies only to prescriptions filled before the program expires on 12/31/19. **5.** Allergan reserves the right to rescind, revoke, or amend this offer without notice. **6.** Offer good only in the USA, including Puerto Rico, at participating retail pharmacies. **7.** Void where prohibited by law, taxed, or restricted. **8.** This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. **9.** This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. **10.** This offer is not health insurance. **11.** This card expires 12/31/19. **12. By redeeming this card, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.**

For questions about this program, including savings on mail-order prescriptions, please call 1-855-285-8115.

Pharmacist Instructions for a Patient with an Eligible Third-Party Payer: When you redeem this card, you certify that you have not submitted and will not submit a claim for reimbursement under any federal, state, or other government programs for this prescription. Submit the claim to the primary Third-Party Payer first, then submit the balance due to **CHANGE HEALTHCARE** using BIN #004682 as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code (eg, 8). If you receive a rejection due to PA, step-edit, or NDC block, submit Other Coverage Code of 3 (Secondary Claim). The patient's out-of-pocket expense will be reduced up to \$75 for a 30-day supply OR up to \$150 for a 90-day supply, the maximum savings limit for the program. Reimbursement will be received from **CHANGE HEALTHCARE**. For any questions regarding **CHANGE HEALTHCARE** online processing, call the Help Desk at **1-800-422-5604**.

Program managed by ConnectiveRx on behalf of Allergan.

To report adverse events, product complaints, or for medical/product questions related to Allergan manufactured U.S. products, call 1-800-678-1605 or visit <http://www.allergan.com/products/drug-safety>.



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