Slynd™ Savings Program

Slynd™ (drospirenone) tablets, 4 mg

SAVINGS PROGRAM

ELIGIBLE PATIENTS MAY
PAY AS LITTLE AS

$10* PER **1-MONTH** PRESCRIPTION FILL

OR

$25* PER **3-MONTH** PRESCRIPTION FILL

3 MONTH FILL MAY COST PATIENT
$8.33 PER MONTH

NO ACTIVATION NEEDED!

Simply ask your pharmacist to apply the savings to your prescription.

Powered by:
CHANGE HEALTHCARE

BIN#	004682
PCN#	CN
GRP#	ECSLYND1
ID#	SLYND

*Maximum savings limits apply; patient out-of-pocket expense will vary depending on insurance coverage. Offer not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs. Please see inside for Program Terms, Conditions, and Eligibility Criteria.

ELIGIBLE PATIENTS MAY ALSO ACCESS SAVINGS VIA **TEXT**

Text **SLYND** to **31700**

Questions? If you have questions about the **Slynd™ Savings Program**, PLEASE DO NOT call your healthcare provider. Simply call us with questions at 1-845-865-8685.

Getting Started on Slynd™

Starting your Slynd™ Prescription*

1. Fill your Slynd™ prescription at the pharmacy and bring your co-pay card obtained from your doctor's office, online, or via text. **Card is good for refills until 12/31/20.**
2. In order to apply savings benefit and reflect your final out of pocket cost, **ask your pharmacist to process your Slynd™ prescription** through your primary insurance along with the copay card.
3. If the pharmacist states the medication is **not covered under your insurance or there is an out-of-pocket cost over $65**, ask the pharmacist to run the prescription as **"cash-pay" and apply the coupon**.
4. **There is no generic equivalent of Slynd™.** If your pharmacist indicates they do not have Slynd™ in stock, ask them to order it and they can have it in **approximately 24 hours**.
5. If you experience any further problems, have your pharmacist call the Help Desk: **1-800-422-5604**.

*Offer not valid for patients enrolled in Medicare, Medicaid, or any other federal or state healthcare program. The patient is responsible for the first $10 or $25 of their co-pay and cash-paying patients should pay approximately $65. See redemption instructions for further details.

Mail-order Patients

If you fill your prescription through a mail-order pharmacy, or if you are unable to have your card processed at your local pharmacy, please submit:

1. A photocopy of the front and back of your Slynd™ Savings Program Card
2. Your original proof of purchase (original pharmacy receipt with your name and address, pharmacy name, product name, prescription numbers, NDC number, date filled, quantity, and price) and a photocopy of the front and back of your insurance card.
3. Your date of birth
4. Mail all of the information to:
   Slynd™ Savings Program
   c/o Connective Rx
   200 Jefferson Park, Whippany, NJ 07981

Please allow 6-8 weeks to receive your reimbursement. Reimbursement requests must be postmarked by December 31, 2020. Reimbursements are subject to Program Terms, Conditions, and Eligibility Criteria.

Program Details

Dear Pharmacist: The patient is responsible for the first $10 of their co-pay for a 1-month supply or $25 for a 3-month supply and cash-paying patients should pay approximately $65. Card is good for refills through 12/31/20. Prescriber ID# required on prescription. **Not valid for individuals enrolled in Medicare, Medicaid, a state pharmaceutical assistance program, or any other federal or state health care program.**

Patient Instructions: In order to redeem this card you must have a valid prescription for Slynd™. The patient is responsible for the first $10 of their co-pay for a 1-month supply or $25 for a 3-month supply and cash-paying patients should pay approximately $65. Card is good for refills through 12/31/20. Follow the dosage instructions given by the doctor. This card may not be redeemed for cash. **You are not eligible for this offer if ou are enrolled in Medicare, Medicaid, or any other federal or state healthcare program. If out-of-pocket cost on the 3-month fill is above $65, ask your pharmacist to process a 1-month fill instead.** Cardholders with questions, please call **1-845-865-8685**.

Pharmacist Instructions for a Patient with an Eligible Third Party Payer: Submit the claim to the primary Third Party Payer first, then submit the balance due to **CHANGE HEALTHCARE** as a Secondary Payer COB [coordination of benefits] with patient responsibility amount and a valid Other Coverage Code, **(e.g. 8)**. The patient is responsible for the first $10 of their co-pay for a 1-month supply or $25 for a 3-month supply. Reimbursement will be received from **CHANGE HEALTHCARE**.

Pharmacist Instructions for a Cash-Paying Patient: Submit this claim to **CHANGE HEALTHCARE**. A valid Other Coverage Code **(e.g. 1)** is required. The patient is responsible for the first $10 of their co-pay for a 1-month supply or $25 for a 3-month supply and cash-paying patients should pay approximately $65. Reimbursement will be received from **CHANGE HEALTHCARE**.

Valid Other Coverage Code required. For any questions regarding this coupon, or **CHANGE HEALTHCARE** online processing, please call the Help Desk at **1-800-422-5604**.

Program expires 12/31/20. Program managed by ConnectiveRx on behalf of Exeltis USA, Inc. The parties reserve the right to rescind, revoke, or amend this offer without notice at any time. Not valid if reproduced. Void where prohibited by law.

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Rethinking healthcare

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