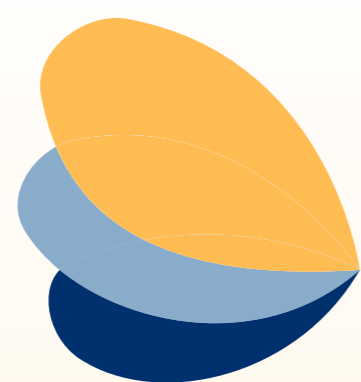


## INSTANT SAVINGS



# Tirosint<sup>®</sup>-SOL

(levothyroxine sodium) oral solution

## PAY AS LITTLE AS

# \$15\*

## ON YOUR PRESCRIPTION

### Maximum Benefit of \$85

To utilize this copay card for your mail-order prescriptions, visit [www.tirosintsol.com](http://www.tirosintsol.com) or call 1-833-666-2501

**Dear Patient:** Present this coupon card to your pharmacist along with your valid prescription for instant savings on eligible prescriptions.

Please see Redemption Instructions below for details.

Restrictions may apply. Please see program restrictions at [www.tirosintsol.com](http://www.tirosintsol.com).

Keep this coupon card for future refills.

**Expires December 31, 2019.**

**Please refer to Full Prescribing Information, including Boxed Warning, at [tirosintsol.com](http://tirosintsol.com).**

\*For qualified patients only. Restrictions apply. Please see program restrictions at [www.tirosintsol.com](http://www.tirosintsol.com). See program rules and eligibility requirements below.

### INSTANT SAVINGS

#### PAY AS LITTLE AS

# \$15\*

## ON YOUR PRESCRIPTION

### Maximum Benefit of \$85

Powered by:  
**CHANGE HEALTHCARE**

BIN# 004682

PCN# CN

GRP# ECTIROSINT7

ID# TIROSINTSOL



### Tirosint<sup>®</sup>-SOL

(levothyroxine sodium) oral solution

Please refer to Full Prescribing Information,  
including Boxed Warning, at [tirosint.com](http://tirosint.com).

\*See full Terms, Conditions, and Eligibility Criteria below.

**Patient Instructions:** In order to redeem this card you must have a valid prescription for at least a month's supply of Tirosint<sup>®</sup>-SOL (levothyroxine sodium) oral solution. Eligible patients will be responsible for the first \$15 and receive up to \$85 off their out-of-pocket expenses. Prescriber ID# required on prescription. **Not valid for prescriptions eligible to be reimbursed under Medicare (including Medicare Part D and Medicare Advantage), Medicaid, TRICARE<sup>™</sup>, CHAMPUS, the Puerto Rico Governmental Health Insurance Plan, or other federal, state, or governmental healthcare programs. Valid in the U.S. only. Accepted by participating pharmacies only. Limitations may apply to Massachusetts and California residents This Copay Assistance Program is not insurance.** Follow the dosage instructions given by the doctor. This card may not be redeemed for cash. Cardholders with questions, please call 1-833-666-2501.

**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 \$15 and the card pays up to the next \$85. 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 \$15 and the card pays up to the next \$85. Reimbursement will be received from **CHANGE HEALTHCARE**.

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

Program managed by ConnectiveRx on behalf of IBSA Pharma 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.

