INSTANT SAVINGS

Tirosint®
(levothyroxine sodium) capsules

For patients with commercial insurance

PAY AS LITTLE AS

$25 PER **1-MONTH** SUPPLY
Maximum Benefit Applies

OR

$50 PER **3-MONTH** SUPPLY ($16.67 per month)
Maximum Benefit Applies

To utilize this copay card for your mail-order prescriptions, visit www.Tirosint.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.Tirosint.com.**

Keep this coupon card for future refills.

Please refer to Full Prescribing Information, including Boxed Warning, at www.Tirosint.com.

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PAY AS LITTLE AS

$25 PER 1-MONTH SUPPLY Maximum Benefit Applies ..... OR ..... $50 PER 3-MONTH SUPPLY Maximum Benefit Applies

BIN#	610020
PCN#	ACR
GRP#	99995025
ID#	31800500201

Tirosint®
(levothyroxine sodium) capsules

Please refer to Full Prescribing Information, including Boxed Warning, at www.Tirosint.com.

Patient Instructions: In order to redeem this card you must have a valid prescription for at least a month's supply of Tirosint® (levothyroxine sodium) capsules. Eligible patients will be responsible for the first $25 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™, 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 PDMI as a Secondary Payer COB [coordination of benefits] with patient responsibility amount and a valid Other Coverage Code, (e.g. 8 or 3). Depending on coverage, the patient may be responsible for the first $25 or more and the card pays up to the next $85 (maximum benefit). Reimbursement will be received from PDMI. Prescriptions for a 3-month supply have a maximum benefit of $280.

Pharmacist Instructions for a Cash-Paying Patient: Submit this claim to PDMI. A valid Other Coverage Code (e.g. 1) is required. The patient is responsible for the first $25 and the card pays up to the next $70. Reimbursement will be received from PDMI. Valid Other Coverage Code required.

IBSA Pharma Inc.reserves the right to rescind, revoke, or amend this offer without notice at any time. Not valid if reproduced. Void where prohibited by law.

For any questions regarding PDMI online processing, please call the **Help Desk at 1-316-219-4802.**

IBSA Caring Innovation

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