

INSTANT SAVINGS



Patients with commercial insurance can

PAY AS LITTLE AS

\$4 PER 1-MONTH SUPPLY
Maximum Benefit Applies

OR

\$0 PER 3-MONTH SUPPLY
Maximum Benefit Applies

To utilize this copay card for your mail-order prescriptions, visit www.TirosintSOL.com or call (312) 913-6886.

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.

Keep this coupon card for future refills.

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



Patient Instructions: In order to redeem this card you must have a valid prescription for at least a month's supply of Tirosint-SOL (levothyroxine sodium) oral solution. Eligible patients will be responsible for the first \$4 and receive up to \$85 (maximum benefit) on their out-of-pocket expenses. Prescriber ID# required on prescription. Prescriptions for a 3-month supply have a maximum benefit of \$280.

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 (312) 913-6886.

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, for a one-month supply that patient may be responsible for the first \$4 or more and the card pays up to the next \$85. For a three month supply, patient may be responsible for as little as \$0 with the card paying a maximum of \$280. Reimbursement will be received from PDMI.

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.

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

