Triptodur®
(triptorelin)
for extended release injectable suspension

Triptodur® Copay Reimbursement Form

Customer Service: (833)-401-CARE (2273)
Fax Form to: 855-246-3986

To receive copay reimbursement:

1. Enroll patient in the Triptodur Copay Program by calling the Triptodur Care Team 833-401-CARE (2273) AND

2. Submit this form along with the documents below via email, fax or mail to determine eligibility.†

Please note this form must be completed for each prescription fill. Please include the supporting documents below to ensure timely eligibility determination and reimbursement.

- **Itemized Explanation of Benefits (EOB)**–*Ensure the document clearly states the product name and/or NDC and the patient's out of pocket expense for Triptodur.*
- **Billing Statement / Itemized Explanation of Payments (CMS 1500 or UB-04)**–*ONLY applicable for institution/prescriber; Ensure documentation includes Triptodur JCode, product name, date of service and patient's out of pocket expense for Triptodur.*

Please keep a copy of all submitted documents.

†For eligible patients only. Not valid for patients covered under Medicaid, Medicare or other government insurance program or where prohibited by law. Out-of-pocket costs paid by this program may not be submitted as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA). Please review Terms and Conditions below.

*REQUIRED

Send Reimbursement to:	REIMBURSEMENT ADDRESS:	EMAIL DOCUMENTS TO:	FAX DOCUMENTS TO:	MAIL DOCUMENTS TO:
☐ Institution ☐ Patient ☐ Prescriber		TriptodurCopay @pantherxrare.com	855–246–3986	Triptodur Care Program 24 Summit Park Drive Pittsburgh, PA, 15275

PATIENT INFORMATION

*Patient First Name: | *Patient Last Name:

*Date of Birth: | *Gender: ☐ M ☐ F ☐ Unspecified

*Address:

*City: | *State: | *Zip Code:

*Caregiver First Name: | *Caregiver Last Name:

*Caregiver Phone: | *Caregiver Email:

*Caregiver Signature: | *Date: | *Relationship to Patient:

PRIMARY INSURANCE INFORMATION

Plan Name: | Cardholder ID: | Group Number:

PRESCRIBER OFFICE CONTACT INFORMATION

Name: | Address: | Phone: | Fax:

INSTITUTION/REIMBURSEMENT SPECIALIST CONTACT INFORMATION

MD Name: | MD Address: | MD Phone: | MD Fax:

Terms and Conditions

By using the Triptodur Copay Assistance, you certify that you currently meet the eligibility criteria and will comply with the Terms and Conditions described below.

- Copay Assistance is not valid for prescriptions that are eligible to be reimbursed, in whole or in part, by Medicaid, Medicare, or other federal or state healthcare programs (including any state prescription drug assistance programs and the Government Health Insurance Plan).
- Copay Assistance is not valid for prescriptions that are eligible to be reimbursed, in whole by commercial plans.
- **Eligible patients may pay as little as $5 out-of-pocket for Triptodur per prescription with the Triptodur Copay Assistance Program.**
- This copay is valid for eligible cash paying patients.
- ***Insured must be 18 years of age or older; patients must be 2 years of age or older.***
- Each patient is limited to one active Copay Assistance Offer at a time during this offering period and the Copay Assistance offer is not transferable.
- Copay Assistance cannot be combined with any other rebate or coupon, free trial, or similar offer for the specified prescription.
- **Copay Assistance will be accepted at participating pharmacies.**
- **Copay Assistance is not health insurance.**
- This offer is good only in the United States and Puerto Rico as allowed by law.
- Azurity reserves the right to rescind, revoke, or amend the Copay Assistance without notice.
- Offer valid until the end of the current calendar year. No membership fees apply.

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