INSTANT SAVINGS

Tirosint®
(levothyroxine sodium) capsules
Tirosint®-SOL
(levothyroxine sodium) oral solution

For patients with commercial insurance

PAY AS LITTLE AS

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

OR

$60 PER **3-MONTH** SUPPLY
Maximum Benefit Applies

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** or **www.Tirosint-SOL.com**

Keep this coupon card for future refills.

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

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PAY AS LITTLE AS

$25 PER 1-MONTH SUPPLY Maximum Benefit Applies ····· OR ····· $60 PER 3-MONTH SUPPLY Maximum Benefit Applies

BIN#	610020
PCN#	ACR
GRP#	99995039
ID#	21481300001

Tirosint®
(levothyroxine sodium) capsules
Tirosint®-SOL
(levothyroxine sodium) oral solution

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

Patient Instructions: In order to redeem this card you must have a valid prescription for at least a 30-day quantity of Tirosint® (levothyroxine sodium) capsules or Tirosint®-SOL (levothyroxine sodium) oral solution. Eligible patients will be responsible for paying the first $25 for a 30-day quantity prescription and any copay amount not covered by the card. Eligible patients will be responsible for the first $60 for a 90-day quantity prescription and any copay amount not covered by the card.

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). Maximum benefit applies. 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 (30-day quantity prescription) or $60 (90-day quantity prescription) and the remaining amount that is not covered by the card. 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.**

IBSA Caring Innovation

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