

## RESTRICTIONS, TERMS, AND CONDITIONS

1. By accepting this offer, you agree to report the value received under this offer to any health insurer or other third party paying for any part of your XIAFLEX<sup>®</sup> prescription if you are required to do so by benefit terms, contract, or law.
2. This offer is not valid for prescriptions reimbursed in whole or in part by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, similar federal or state programs, or where otherwise prohibited by law.
3. By accepting this offer, you agree that Endo or those working on its behalf may contact your doctor to verify information about treatment that is relevant to verifying your eligibility for this offer.
4. This offer is only valid for doses of XIAFLEX<sup>®</sup> administered in the US.
5. This offer is valid for the out-of-pocket cost for the dose of XIAFLEX<sup>®</sup> only. Offer is not valid for any other products or other out-of-pocket costs (for example, office visit charges, office visit copays, or injection/administration costs) even if those costs are associated with the administration of a dose of XIAFLEX<sup>®</sup>.
6. This offer is valid only if you have not used this program within the last 30 days.
7. The selling, purchasing, trading, or counterfeiting of this offer is prohibited.
8. Endo Pharmaceuticals Inc. reserves the right to rescind, revoke, or amend this offer without notice. You will have up to 365 days after receipt of your Explanation of Benefits (EOB) to submit this offer for processing.
9. By participating, you understand and agree to comply with the terms and conditions of this offer as set forth above.

Please keep this card. You will need to provide information on it to your Specialty Pharmacy if your prescription for XIAFLEX<sup>®</sup> is processed through them.

**XIAFLEX<sup>®</sup>**  
collagenase clostridium histolyticum

## XIAFLEX<sup>®</sup> COPAY PROGRAM PATIENT ELIGIBILITY:

You are eligible for assistance under this program if:

- You are receiving or received XIAFLEX<sup>®</sup> for the approved indication and in a manner consistent with the instructions for administration of XIAFLEX<sup>®</sup>
- You are uninsured or have insurance that is not provided by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, or similar federal or state programs, and this program is not otherwise prohibited by law
- You are 18 years of age or older
- You have paid or are obligated to pay out-of-pocket costs for a dose of XIAFLEX<sup>®</sup>

No other purchase is necessary to receive this offer.

For more information, call  
**877-XIAFLEX**  
or visit **XIAFLEX.com**

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collagenase clostridium histolyticum



### Rx Only

XIAFLEX<sup>®</sup> is a registered trademark of Endo International plc or one of its affiliates.  
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MM-05200/December 2017 www.xiaflex.com 1-800-462-ENDO (3636)

## XIAFLEX<sup>®</sup> COPAY CARD

Eligible patients can receive up to \$1200 toward their out-of-pocket costs for each vial of XIAFLEX<sup>®</sup>.

Emdeon  
Therapy First Plus

BIN# 004682  
PCN# CN  
GRP# EC22001008  
ID# 38607926518

**XIAFLEX<sup>®</sup>**  
collagenase clostridium histolyticum

For more information, visit us at [XIAFLEX.com](http://XIAFLEX.com)

**Patient instructions:** Eligible patients may reduce their out-of-pocket cost by up to \$1200 on each vial of XIAFLEX<sup>®</sup>. A valid prescriber ID# is required on the prescription. This offer is valid toward out-of-pocket expenses for XIAFLEX<sup>®</sup>. Cardholders with questions should call 1-866-585-5591.

**Pharmacist instructions for a patient with an Eligible Third-Party Payor:** Submit the claim to the primary Third-Party Payor first, then submit the balance due to **Therapy First Plus** as a Secondary Payor COB [coordination of benefits] with patient responsibility amount and a valid Other Coverage Code, (e.g. 8). The patient pay amount submitted will be reduced by up to \$1200 for each vial of XIAFLEX<sup>®</sup> and reimbursement will be received from **Therapy First Plus**.

**Pharmacist instructions for a cash-paying patient:** Submit this claim to **Therapy First Plus**. A valid Other Coverage Code (e.g. 1) is required. The patient pay amount submitted will be reduced by up to \$1200 for each vial of XIAFLEX<sup>®</sup> and reimbursement will be received from **Therapy First Plus**. For any questions regarding **Therapy First Plus** online processing, please call the Help Desk at 1-800-422-5604.

Offer not valid when patient is insured in whole or in part through Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, or similar federal or state programs, or where offer is otherwise prohibited by law. If you are eligible for XIAFLEX<sup>®</sup> coverage and reimbursement under any such program, you cannot use this card.

Programs managed by PSKW & Associates on behalf of Endo Pharmaceuticals Inc. The parties reserve the right to amend or end this program at any time without prior notice. Product dispensed pursuant to program rules and federal and state laws.

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