Copay Savings Program Reimbursement Form

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® prescription if you are required to do so by benefit terms, contract, or law. 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. By accepting this offer, you agree that Endo Pharmaceuticals Inc. 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. This offer is only valid for doses of XIAFLEX® administered in the US. This offer is valid for the out-of-pocket cost for the dose of XIAFLEX® 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®. The selling, purchasing, trading, or counterfeiting of this offer is prohibited. Endo Pharmaceuticals Inc. reserves the right to rescind, revoke, or amend this offer without notice. By participating, you understand and agree to comply with the terms and conditions of this offer as set forth above. Please see XIAFLEX.com for additional patient eligibility requirements.

PRACTICE BILLING INFORMATION (all fields are required)

Practice Name (check will be made payable to) ______ Practice NPI ______ Practice Tax ID ______

Address 1 ______ Address 2 ______

City ______ State ______ ZIP ______

Contact Phone Number ______ Email Address ______

Physician First Name ______ Physician Last Name ______ Physician NPI ______

PATIENT INFORMATION—MUST BE SIGNED BY PATIENT (all fields are required)

First Name ______ Middle ______ Last Name ______ Gender ______

Address 1 ______ Address 2 ______

City ______ State ______ ZIP ______ Date of Birth ______

Phone ______ Email ______

XIAFLEX® Copay Savings Program Group # EC22001005 XIAFLEX® Copay Savings Program ID # 38607926518

PATIENT CERTIFICATION AND CONSENT—MUST BE SIGNED BY PATIENT

"I certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the copayment or out-of-pocket expenses requested for reimbursement were actually incurred. I also certify that the XIAFLEX® I received was not reimbursed in whole or in part by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, or similar federal or state programs."

Patient Signature: ______

Please remit assistance to (select 1):

☐ Patient

☐ Practice/Physician (If Practice option is selected, payment will be made in accordance with the Practice Information provided above.)
Assignment of Benefits
I hereby assign all financial assistance available to me through the XIAFLEX® Copay Savings Program to be payable to Practice listed above. Practice will receive all financial assistance, on my behalf, through the XIAFLEX® Copay Savings Program and will credit my account accordingly.

Patient Signature: ______ Date ______

REIMBURSEMENT PROCESS

Complete this form in its entirety and submit it with the following items:

- For insured patients: Attach a copy of the Explanation of Benefits (EOB) highlighting the out-of-pocket expenses for XIAFLEX®.
- For cash-paying patients: Attach the receipt indicating the amount paid by the patient for XIAFLEX®.

Submit reimbursement claim and attachments via mail, fax, or email:

Mail: XIAFLEX® Copay Savings Program
PO Box 2355
Morristown, NJ 07962

Fax: 1-908-809-6249

Email: xiaflex@connectiverx.com

Note: Forms sent via fax or email will take up to 10 business days to process. Forms sent by mail may take up to 15 business days to process.

For additional questions about your XIAFLEX® treatment, please call 877-XIAFLEX (877-942-3539).
For questions about the XIAFLEX® Copay Savings Program, the program offer, or this form, please call 1-866-585-5591.

How the XIAFLEX® Copay Savings Program May Help Cover Out-of-Pocket Costs

If you are billing your patient's insurance plan for XIAFLEX® (collagenase clostridium histolyticum), or if your patient is paying cash for the XIAFLEX® injections, your patient may be eligible to participate in the XIAFLEX® Copay Savings Program. Eligible patients can receive up to $1200 toward their out-of-pocket cost for each vial of XIAFLEX®. Please see XIAFLEX.com for additional patient eligibility requirements.

The XIAFLEX® Copay Savings Program Process

Determine your patient's insurance status and coverage for XIAFLEX®

Administer XIAFLEX®

If your patient is insured, submit a claim for XIAFLEX® to your patient's insurance plan

You and your patient will receive an Explanation of Benefits (EOB), indicating the exact amount that was reimbursed and the exact amount your patient owes for XIAFLEX®

For eligible patients, submit the XIAFLEX® claim form to the program via fax, email, or mail. Claims should be accompanied by a copy of the EOB for insured patients or a copy of the receipt for cash patients

The program will provide reimbursement up to the maximum amount allowed

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Morristown, NJ 07962

Fax: 1-908-809-6249

Email: xiaflex@connectiverx.com

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