

Tyblume®

(levonorgestrel and ethinyl estradiol)
tablets, 0.1 mg/0.02 mg



PATIENT SAVINGS PROGRAM

ELIGIBLE PATIENTS MAY
PAY AS LITTLE AS

\$0*

PER 3-MONTH
PRESCRIPTION FILL

*Maximum savings limits apply; patient out-of-pocket expense will vary depending on insurance coverage. Offer not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs. Please see Program Terms, Conditions, and Eligibility Criteria.

NO ACTIVATION NEEDED!

Simply ask your pharmacist to apply the savings to your prescription.

Powered by
CHANGE HEALTHCARE

BIN: 600426

PCN: 54

GRP: ECTYBLUME1

ID: TYBLUME

ELIGIBLE PATIENTS
MAY ALSO ACCESS
SAVINGS VIA **TEXT**



Text
TYBLUME
to **31700†**

†Text TYBLUME to 31700 to receive your Exeltis Women's Health Savings Card. Message and data rates may apply. Message frequency varies. Text STOP to opt out. Text HELP for help. For Privacy Policy: <https://exeltisusa.com/privacy-policy/>. For SMS Terms: <https://exeltis.online/SMStext>.

Questions? If you have questions about the Exeltis Women's Health Savings Program, PLEASE DO NOT call your healthcare provider. Simply call us with questions at **1-833-210-5451**.

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PATIENT SAVINGS PROGRAM

How to get started on your Tyblume® Prescription*

1. Fill your Tyblume® prescription at the pharmacy and bring your co-pay card obtained from your doctor's office.
2. In order to apply savings benefit and reflect your final out of pocket cost, **ask your pharmacist to process your Tyblume® prescription** through your primary insurance along with the copay card.
3. If the pharmacist states the medication is **not covered under your insurance or there is an out-of-pocket cost over \$10**, ask the pharmacist to run the prescription as **"cash-pay" and apply the coupon**.
4. **There is no generic equivalent of Tyblume®.** If your pharmacist indicates they do not have Tyblume® in stock, ask them to order it and they can have it in **approximately 24 hours**.
5. If you experience any further problems, have your pharmacist call the Help Desk: **1-800-433-4893**.

*Offer not valid for patients enrolled in Medicare, Medicaid, or any other federal or state healthcare program. See redemption instructions for further details.

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PATIENT SAVINGS PROGRAM

Mail-order Patients

If you fill your prescription through a mail-order pharmacy, or if you are unable to have your card processed at your local pharmacy, please submit:

1. A photocopy of the front and back of your Patient Savings Program Card
2. Your original proof of purchase (original pharmacy receipt with your name and address, pharmacy name, product name, prescription numbers, NDC number, date filled, quantity, and price) and a photocopy of the front and back of your insurance card.
3. Your date of birth
4. Mail all of the information to:
Tyblume® Claims Processing Dept.
PO Box 2355
Morristown, NJ 07962

Please allow 6-8 weeks to receive your reimbursement. Reimbursements are subject to Program Terms, Conditions, and Eligibility Criteria.

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Program Terms, Conditions, and Eligibility Criteria: 1. This offer is available to patients with commercial prescription insurance coverage and cash paying pharmacy for a valid prescription of TYBLUME® at the time the prescription is filled by the pharmacist and dispensed to the patient. 2. This offer is not valid for use by patients enrolled in Medicare, Medicaid, or other federal or state programs (including any state pharmaceutical assistance programs), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs, or where prohibited by law or by the patient's health insurance provider. Patients may not use this offer if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug coverage program for retirees. If at any time a patient begins receiving prescription drug benefit under any such federal, state, or government-funded healthcare program, patient will no longer be eligible to use the Patient Savings Program. 3. Most commercially insured and cash-paying patients should pay approximately \$0 for a 1-month or 3-month supply. The amount may vary slightly across pharmacies. Check with your pharmacist for your copay discount. Maximum savings limits apply; patient out-of-pocket expense will vary. 4. Exeltis USA, Inc. reserves the right to rescind, revoke, or amend this offer without notice. 5. Offer good only in the USA, including Puerto Rico, at participating retail pharmacies. Patients residing in or receiving treatment in certain states may not be eligible. 6. Void where prohibited by law, taxed, or restricted. 7. Patients may not seek reimbursement for value received from the Patient Savings Program from any third-party payers. 8. This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. 9. This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. 10. This offer is not health insurance. 11. By redeeming this card, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.

Pharmacist Instructions for a Patient with an Eligible Third Party Payer: When you redeem this card, you certify that you have not submitted and will not submit a claim for reimbursement under any federal, state, or other government programs for this prescription. Submit the claim to the primary Third-party Payer first, then submit the balance due to CHANGE HEALTHCARE using BIN #600426 as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code (e.g. 8). If you receive a rejection due to PA, step-edit, or NDC block, submit Other Coverage Code of 03 (Secondary Claim). The patient's out of pocket expense will be reduced up to the maximum savings limit of the program. Reimbursement will be received from CHANGE HEALTHCARE.

Pharmacist Instructions for a Cash-Paying Patient: Submit this card to CHANGE HEALTHCARE. A valid Other Coverage Code (e.g. 1) is required. The patient should pay approximately \$0 for a 1 or 3 month supply. Reimbursement will be received from CHANGE HEALTHCARE.

Valid Other Coverage Code required. For any questions regarding this coupon, or CHANGE HEALTHCARE online processing, please call the Help Desk at **1-800-433-4893**.

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