Stay on Branded CRESTOR,

pay as low as $3* for a 3-month supply with no activation required.

CRESTOR®
rosuvastatin

*For eligible commercially insured patients. Subject to eligibility and monthly savings limit. Restrictions apply.

Simply follow the below instructions and you may pay as low as $3 on out-of-pocket cost (up to a savings limit of $175 per 30-day supply, $350 per 60-day supply, or $525 per 90-day supply) on your CRESTOR prescription.

CRESTOR Eligible Patient Mail-In Order Form

INSTRUCTIONS

To receive your reimbursement payment check within 6 to 8 weeks for a valid prescription claim, please complete the following steps:

1. Fill a prescription at your mail-order pharmacy.
2. Print, fill out, and sign this form.
3. Mail this form along with the original Mail-Order Pharmacy Receipt that you received for your prescription (cash register receipts are not acceptable). Forms submitted without these items will not be valid and therefore will not be eligible for reimbursement.

THE MAIL-ORDER PHARMACY RECEIPT SHOULD INCLUDE:

- Patient name and address
- Prescription number or Rx number, fill date, drug name, strength and NDC number
- Quantity, price and/or co-pay amount paid
- Mail-order pharmacy name, address and phone number

Provide the information below to receive your refund

Patient Name _____ Date of Birth (mm/dd/yy) _____

Address _____

City _____ State _____ ZIP _____

Phone _____ E-mail (optional) _____

BIN# 004682 **PCN# CN** **GRP# EC57002228** **ID# 415425914642**

I, _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the co-payment or out-of-pocket expenses requested for reimbursement were actually incurred.

I, _____, certify that my prescription was not purchased under a state- or federally funded presciption insurance program, including Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs, or Tricare, that I am not Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Refer to the product prescription savings card program for complete terms and conditions.

Patient Signature _____ **Date** _____

Mail your completed form and original Mail-Order Pharmacy receipt to: AstraZeneca Claims Processing Dept, PO Box 2355, Morristown, NJ 07962

If you have any questions regarding the offer, please call 1-800-236-9933. AstraZeneca reserves the right to change or discontinue prescription program savings offers at any time without notice.

ELIGIBILITY: You may be eligible for this offer if you are insured by commercial insurance and your insurance does not cover the full cost of your prescription, or you are not insured and are responsible for the cost of your prescriptions. Patients who are enrolled in a state or federally funded prescription insurance program are not eligible for this offer. This includes patients enrolled in Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD) programs, or TriCare, and patients who are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. If you are enrolled in a state- or federally funded prescription insurance program, you may not use this savings card even if you elect to be processed as an uninsured (cash-paying) patient. This offer is not insurance, is restricted to residents of the United States and Puerto Rico, and to patients over 7 years of age.

TERMS OF USE: Eligible commercially insured/covered patients with no restrictions (step-edit, prior authorization, or NDC block) and a valid prescription for CRESTOR® (rosuvastatin) Tablets who present this savings card at participating pharmacies may pay as low as $3 for each 30, 60, or 90-day supply, subject to a maximum savings of $150 per 30, $300 per 60, or $450 per 90-day supply. Patient out-of-pocket expenses may vary. If you are insured and your insurance does not cover or has a managed care restriction on your prescription (step-edit, prior authorization, or NDC block), AstraZeneca will pay up to the first $175 for a 30-day supply, $350 for a 60-day supply, or $525 for a 90-day supply, and you will be responsible for any remaining balance, for each monthly prescription. If you pay cash for your prescription, AstraZeneca will pay up to the first $150 for a 30-day supply, and you will be responsible for any remaining balance, for each monthly prescription. Other restrictions may apply. Patient is responsible for applicable taxes, if any. Non-transferable, limited to one per person, cannot be combined with any other offer. Void where prohibited by law, taxed, or restricted. Patients, pharmacists, and prescribers cannot seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this offer. AstraZeneca reserves the right to rescind, revoke, or amend this offer, eligibility, and terms of use at any time without notice. This offer is not conditioned on any past, present, or future purchase, including refills. Offer must be presented along with a valid prescription at the time of purchase. If you have any questions regarding this offer, please call 1-855-687-2151.

BY USING THIS CARD, YOU AND YOUR PHARMACIST UNDERSTAND AND AGREE TO COMPLY WITH THESE ELIGIBILITY REQUIREMENTS AND TERMS OF USE.

Pharmacist Instructions for a Patient With an Eligible Third Party: For Insured/Covered Patients: Submit the claim to the primary Third-Party Payer first, then submit the balance due to **CHANGE HEALTHCARE** as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 8. This may reduce the eligible patient's out-of-pocket costs to as low as $3 for each 30, 60, or 90-day supply, subject to a maximum savings limit of $150 per 30, $300 per 60, or $450 per 90-day supply. Patient out-of-pocket expenses may vary. Reimbursement will be received from **CHANGE HEALTHCARE**.

Pharmacist Instructions for Insured/Not Covered Patients: Submit the claim to the primary Third-Party Payer first; if the primary claim submission shows a managed care restriction (step-edit, prior authorization, or NDC block), continue the claim adjudication process and submit the balance due to **CHANGE HEALTHCARE** as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 3. This may reduce eligible patient's out-of-pocket costs to as low as $3, subject to a maximum savings limit of $175 per 30-day supply. Patient out-of-pocket expenses may vary. Reimbursement will be received from **CHANGE HEALTHCARE**.

Pharmacist Instructions for a Cash-Paying Patient: Submit this claim to **CHANGE HEALTHCARE**. A valid Other Coverage Code (eg, 1) is required. The card will cover up to a maximum of $150 per 30-day supply. Reimbursement will be received from **CHANGE HEALTHCARE**. Valid Other Coverage Code Required.

For any questions regarding CHANGE HEALTHCARE online processing, please call the Help Desk at 1-800-422-5604.