

SAVINGS PROGRAM FOR VITAFOL® FAMILY

#1

PRESCRIBED PRENATAL VITAMIN



Select-OB+DHA

Vitafol-OB+DHA

Eligible patients may
PAY AS LITTLE AS

\$25

PER 1-MONTH OR 3-MONTH PRESCRIPTION FILL*

*See below for program details.

NO ACTIVATION NEEDED!

3-month fill
may cost patient

\$8.33

per month

Powered by:

CHANGE HEALTHCARE

BIN# 004682

PCN# CN

GRP# EC90001006

ID# 48650627027

Eligible Patients may
also access via **text**



Text
VITAFOL to 26729

TAKE THE FIRST STEP WITH VITAFOL®



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 Savings 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: Vitafol® Savings Program
c/o ConnectiveRx
200 Jefferson Park, Whippany, NJ 07981

Please allow 6-8 weeks to receive your reimbursement. Reimbursement requests must be postmarked by December 31, 2019. Reimbursements are subject to Program Terms, Conditions, and Eligibility Criteria.

Dear Pharmacist: The patient is responsible for the first \$25 of their co-pay and cash-paying patients should pay approximately \$65. Card is good for refills through 12/31/19. Prescriber ID# required on prescription. **Not valid for individuals enrolled in Medicare, Medicaid, a state pharmaceutical assistance program, or any other federal or state health care program.**

Patient Instructions: In order to redeem this card you must have a valid prescription for Vitafol®-Ultra, Vitafol Fe+, Vitafol-One, Vitafol-OB+DHA, Select-OB+DHA, Select OB, or Vitafol Gummies. The patient is responsible for the first \$25 of their co-pay and cash-paying patients should pay approximately \$65. Card is good for refills through 12/31/19. Follow the dosage instructions given by the doctor. This card may not be redeemed for cash. **You are not eligible for this offer if you are enrolled in Medicare, Medicaid, or any other federal or state healthcare program. If out-of-pocket cost on the 90-day fill is above \$60, ask your pharmacist to process a 30-day fill instead.** Cardholders with questions, please call **1-855-881-3090**.

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 **CHANGE HEALTHCARE** as a Secondary Payer COB [coordination of benefits] with patient responsibility amount and a valid Other Coverage Code, (e.g. **8**). The patient is responsible for the first \$25 of their co-pay. 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 (e.g. **1**) is required. The patient is responsible for the first \$25 of their co-pay and cash-paying patients should pay approximately \$65. 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 **1-800-422-5604**.

Program expires 12/31/19. Program managed by ConnectiveRx on behalf of Exeltis USA, Inc. The parties reserve the right to rescind, revoke, or amend this offer without notice at any time. Not valid if reproduced. Void where prohibited by law.

