

## AVEED<sup>®</sup> Copay Assistance Program

### Pay as little as **\$0** per injection for AVEED<sup>®</sup>

How much you pay for AVEED<sup>®</sup> will depend on your health benefits or insurance coverage.

- With the AVEED<sup>®</sup> Copay Assistance Program, eligible patients with commercial insurance plans may pay a \$0 copay for AVEED<sup>®</sup>
- The AVEED<sup>®</sup> Copay Assistance Program can cover up to \$300 of your out-of-pocket costs for each injection of AVEED<sup>®</sup>

To find out if you qualify, call 1-800-381-2638.

**MAJORITY OF ELIGIBLE PATIENTS  
WITH COMMERCIAL INSURANCE PLANS**

**PAID \$0 OUT-OF-POCKET\***

with the AVEED<sup>®</sup> Copay Assistance Program

\*January 2016 through May 2020 = 21,188 claims filed.

## How the Copay Assistance Program May Help Cover Out-of-Pocket Costs

- 1** If your patient is insured, submit a claim for AVEED<sup>®</sup> to your patient's insurance plan.
- 2** 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 AVEED<sup>®</sup>.
- 3** For eligible patients, submit the AVEED<sup>®</sup> claim form to the program via fax, mail, or online. Claims should be accompanied by a copy of the EOB and copy of the billing statement for insured patients or a copy of the billing statement for cash patients.
- 4** The program will provide reimbursement up to the maximum amount allowed in 4-6 weeks.

### Some restrictions apply:

- Offer good only in the USA and void where prohibited or otherwise restricted by law
- Offer is valid for patients with private insurance or paying cash
- Offer not valid for prescriptions that may be reimbursed under a federal or state healthcare program, including Medicare, Medicaid, or any other federal or state healthcare programs, including any state medical pharmaceutical assistance programs

If there are any questions, please call 1-800-381-2638. Limitations apply. Endo USA, Inc. reserves the right to rescind, revoke, or amend this program without notice.

Patient is responsible for reporting receipt of program rewards to any private insurer that pays for or reimburses any part of the prescriptions filled with this program.

This program is only available to patients who have been diagnosed with the approved medical condition.

## Copay Assistance Program Rebate 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 AVEED® (testosterone undecanoate) injection 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 USA, 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 AVEED® administered in the US. This offer is valid for the out-of-pocket cost for the dose of AVEED® 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 AVEED®. The selling, purchasing, trading, or counterfeiting of this offer is prohibited. Endo USA, 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 [AveedUSA.com](http://AveedUSA.com) for additional patient eligibility requirements.

### Practice Billing Information (all fields are required)

Physician/  
Practice Name  Address   
City  State  ZIP   
Contact Phone Number  Email Address

### Patient Information – Must Be Signed by Patient (all fields are required)

First Name  Middle  Last Name   
Address 1  Address 2   
City  State  ZIP  Date of Birth   
Phone  Email Address   
Injection # (Which injection is this? For example, 1st, 2nd, 3rd, 4th, etc)

### Claim Information

Patient out-of-pocket amount

### Patient Certification and Consent – Must Be Signed by Patient

By signing below, I acknowledge and attest to the following: (1) The AVEED® Copay Assistance Program assists with out-of-pocket costs related to AVEED® (drug only). No other expenses are covered by this program; (2) A failure by me or my physician to follow the program rules may void my participation in the program; (3) I am not covered by a federal- or state-funded health insurance program; (4) I have been diagnosed with hypogonadism (low testosterone).

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 AVEED® Copay Assistance Program to be payable to Practice listed above.  
Practice will receive all financial assistance, on my behalf, through the AVEED® Copay Assistance 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) specifying total price of AVEED® and billing statement indicating the amount you paid for AVEED®.
- For cash-paying patients: Attach the billing statement indicating the amount you paid for AVEED®.

Forms submitted without these items will not be valid and will not be eligible for processing. Please allow 4-6 weeks for processing. Submit reimbursement claim and attachments via mail, fax, or online:

**Mail:** AVEED® Copay Assistance Program  
680 Century Point  
Suite 1000  
Lake Mary, FL 32746

**Fax:** 1-800-872-2056

**Online:** [AveedUSA.com/PatientSavingsProgram](http://AveedUSA.com/PatientSavingsProgram)

For questions about the AVEED® Copay Assistance Program, the program offer, or this form, please call 1-800-381-2638.

Click for full [Prescribing Information](#), including [Boxed Warning](#) and [Medication Guide](#), for patients.

