Euflexxa Relief Program

After your 3rd injection with EUFLEXXA, please follow the steps below to submit your copay claims.

Please complete all fields on this form and submit with all required information and attachments to be considered for reimbursement. See Instructions below.

How to redeem your rebate:

Patient submits the following via Mail /Fax or online through the Euflexxa Relief Program Portal:

1. Health Care Provider Itemized Receipt or EOB
2. Copy of Patient Health Insurance Card (front and back)
3. This Completed Form

✓ Patients with approved claims will receive reimbursement, via check *(mail)*

Please allow 2 – 4 weeks for processing.

Would you like to help us support healthcare workers by donating $5 of your rebate to Direct Relief? Ferring will match each donation.

Do not submit claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE or any state or federally funded programs, nor for any amount covered by insurance, FSA or HSA - none of which are eligible for payment.

I choose to donate $5 to Direct Relief

Patient Information

First Name: _____

Last Name: _____

Date of Birth: _____-_____-_____

Address (Street): _____

Apt./Suite No. _____

City: _____ **State:** _____ **Zip:** _____

Phone: Home / Cell (____) _____ - _____

RxBIN# 601341

RxPCN# OHCP

RxID# K41100521323

RxGrp# OH1605021

I choose not to donate $5 to Direct Relief

Patient Information

First Name:_____

Last Name: _____

Date of Birth: _____-_____-_____

Address (Street): _____

Apt./Suite No. _____

City: _____**State:** _____ **Zip:** _____

Phone: Home / Cell (____) _____ - _____

RxBIN# 601341

RxPCN# OHCP

RxID# K40100593637

RxGrp# OH1605011

IQVIA, Inc. / 77 Corporate Dr. / Bridgewater, NJ 08807 / Attn: Claims Processing Dept. Tel: 1-833-280-9558

Submission of Forms

Mail, Fax or submit your completed form along with the following:

- Explanation of Benefits (EOB) or Itemized receipt inclusive of patient portion paid to the Health Care Provider (HCP)
- Attached copy of Patient's Health Insurance Card (front and back)

Failure to include any of the following will result in claim rejection.

Submission Options:
Mail: Attn: Claims Processing Department, IQVIA, Inc. 77 Corporate Dr. Bridgewater, New Jersey 08807
Fax: 1-631-822-2893
Submit online through the Euflexxa Patient Savings Portal: https://euflexxa.patientsavings.com

Terms and Conditions

This card is not valid for prescriptions submitted for reimbursement to Medicare, Medicaid, 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. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees (i.e., they are eligible for Medicare Part D but receive a prescription drug benefit through a former employer). This card is good for use only with a valid EUFLEXXA prescription at the time the prescription is filled by the pharmacist and dispensed to the patient. Offer good only in the USA at participating specialty pharmacies and health care providers in-office. Void if prohibited by law, taxed, or restricted. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. This card is good for 3 injections or until program expires, whichever comes first. Patient MUST receive all 3 injections to qualify for the program. Ferring Pharmaceuticals Inc. reserves the right to rescind, revoke, or amend this offer without notice. By redeeming this card, you acknowledge that the patient is an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.

Certification Statement

"I,_____, certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state or federally funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law"

Claimant/Legal Guardian Signature: _____Date: _____

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