



Terms, Conditions and Eligibility Requirements:

To the Patient:

Eligible Patients must have a valid prescription for AUSTEDO®. No substitutions permitted. Eligible Patients must have commercial insurance coverage for AUSTEDO®. Patients with commercial insurance coverage that does not provide formulary coverage for AUSTEDO® are NOT eligible for this Program. Uninsured and cash-paying patients are NOT eligible for this Program. Patients enrolled in any state or federally funded healthcare program, including but not limited to, Medicare, Medigap, Medicaid, VA, DOD, TRICARE, Puerto Rico Government Health Insurance Plan, and Medicare-eligible patients enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees, are NOT eligible for this Program. This Program is restricted to residents of the United States and United States territories. By redeeming this offer, you acknowledge that you are an eligible patient and you understand and agree to comply with the terms and conditions of this offer.

Eligible Patients may pay as little as \$0 on each fill. Maximum annual benefits apply and out of pocket expenses may vary. Patient is responsible for costs above maximum benefit amounts. Commercially insured patients whose insurer requires a prior authorization for AUSTEDO® may receive a 30 day supply of AUSTEDO® (up to a total of three prescriptions with only one prescription per AUSTEDO® strength or NDC) under the Program while their prior authorization is pending. If the prior authorization is approved by the commercial insurer, then the patient remains eligible for the Program. If the prior authorization is denied by the commercial insurer, then the patient is no longer eligible for this Program and may not receive any additional Program benefits. If you have any questions regarding your eligibility or benefits, please call the AUSTEDO® Copay Program at 1-800-887-8100.

This Program is not insurance. Void if copied, transferred, purchased, altered or traded, and where prohibited and restricted by law. The Program is not transferable. No substitutions are permitted. The Program form may not be sold, purchased, traded, or counterfeited. Void if reproduced. The Program benefit cannot be combined with any other financial assistance program, free trial, discount, prescription savings card, or other offer. Teva Pharmaceuticals USA, Inc. and its affiliates reserves the right to make eligibility determinations, to set Program benefit maximums, to monitor participation, and to change, rescind, revoke, or discontinue this Program at any time without notice. Limit one Program enrollment per individual. If you have any questions regarding this Program, your eligibility or benefits or if you wish to discontinue your participation, call the AUSTEDO® Copay Program at 1-800-887-8100. These Terms and Conditions are valid for AUSTEDO® dispensed between 1/1/2020 and 12/31/2020. **Expiration Date: 12/31/2020.**

To the Pharmacist:

When you apply this offer, you are certifying that you have not submitted and will not submit a claim for reimbursement under any federal, state, or other governmental program for this prescription.

Pharmacist Instructions: Submit claim to Therapy First Plus. If primary coverage exists, input offer information as secondary coverage and transmit using the COB segment of the NCPDP transaction.

For questions regarding processing, please call the Help Desk 1-800-422-5604.