

Slynd®

(drospirenone) tablets, 4mg

Patient Savings Program

How to get started on your Slynd® Prescription*

1. Fill your Slynd® prescription at the pharmacy and bring your co-pay card obtained from your doctor's office, online, or via text.
2. In order to apply savings benefit and reflect your final out of pocket cost, **ask your pharmacist to process your Slynd® prescription** through your primary insurance along with the copay card.
3. If the pharmacist states the medication is **not covered under your insurance or there is an out-of-pocket cost of over \$40 for a 1-month supply and over \$65 for a 3-month supply**, ask the pharmacist to run the prescription as **"cash-pay" and apply the coupon**.
4. **There is no generic equivalent of Slynd®.** If your pharmacist indicates they do not have Slynd® in stock, ask them to order it and they can have it in **approximately 24 hours**.
5. If you experience any further problems, have your pharmacist call the Help Desk: **1-833-210-5451**.

*Offer not valid for patients enrolled in Medicare, Medicaid, or any other federal or state healthcare program. The patient is responsible for the first \$25 of their co-pay and cash-paying patients should pay approximately \$65. See redemption instructions for further details.

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Program Terms, Conditions, and Eligibility Criteria: 1. This offer is available to patients with commercial prescription insurance coverage and cash paying patients for a valid prescription of SLYND® at the time the prescription is filled by the pharmacist and dispensed to the patient. 2. This offer is not valid for use by patients enrolled in Medicare, Medicaid, or 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, or where prohibited by law or by the patient's health insurance provider. Patients may not use this offer if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. If at any time a patient begins receiving prescription drug coverage under any such federal, state, or government-funded healthcare program, patient will no longer be eligible to use the Patient Savings Program. 3. Depending on insurance coverage, the patient is responsible for the first \$25 of their co-pay for a 1-month or 3-month supply; most cash-paying patients should pay approximately \$35 for a 1-month supply and under \$60 for a 3-month supply. The amount will vary across pharmacies. Check with your pharmacist for your copay discount. Maximum savings limits apply; patient out-of-pocket expense will vary. 4. Exeltis USA, Inc. reserves the right to rescind, revoke, or amend this offer without notice. 5. Offer good only in the USA, including Puerto Rico, at participating retail pharmacies. Patients residing in or receiving treatment in certain states may not be eligible. 6. Void where prohibited by law, taxed, or restricted. 7. Patients may not seek reimbursement for value received from the Patient Savings Program from any third-party payers. 8. This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. 9. This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. 10. This offer is not health insurance. 11. By redeeming this card, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.

Pharmacist Instructions for a Patient with an Eligible Third-Party Payer: When you redeem this card, you certify that you have not submitted and will not submit a claim for reimbursement under any federal, state, or other government programs for this prescription. Submit the claim to the primary Third-party Payer first, then submit the balance due to **CHANGE HEALTHCARE** using BIN #004682 as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code (e.g., 8). If you receive a rejection due to PA, step-edit, or NDC block, submit Other Coverage Code of 03 (Secondary Claim). The patient's out of pocket expense will be reduced up to the maximum savings limit of the program. 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 for a 1-month supply or \$25 for a 3-month supply 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 **1-833-210-5451**.

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.



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connective®

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PATIENT SAVINGS PROGRAM

ELIGIBLE PATIENTS MAY
PAY AS LITTLE AS

\$25* PER 1-MONTH
OR 3-MONTH
PRESCRIPTION FILL
3 MONTH FILL MAY COST PATIENT
\$8.33 PER MONTH

**NO ACTIVATION
NEEDED!**

Simply ask your
pharmacist to apply
the savings to
your prescription.

Powered by:
CHANGE HEALTHCARE

BIN# 004682
PCN# CN
GRP# ECSLYNDHT
ID# SLYND

*Maximum savings limits apply; patient out-of-pocket expense will vary depending on insurance coverage. Offer not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs. Please see back of card for Program Terms, Conditions, and Eligibility Criteria.

ELIGIBLE PATIENTS MAY
ALSO ACCESS SAVINGS
ONLINE OR VIA TEXT



Visit
SLYND.COM



Text
SLYND2 to 31700

†Text SLYND2 to 31700 to receive your Exeltis Women's Health Savings Card. Message and data rates may apply. Message frequency varies. Text STOP to opt out. Text HELP for help. For Privacy Policy: <https://exeltisusa.com/privacy-policy/>. For SMS Terms: <https://exeltis.online/SMStext>.

Questions? If you have questions about the **Patient Savings Program**, PLEASE DO NOT call your healthcare provider. Simply call us with questions at 1-833-210-5451.

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Patient Savings Program

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 Patient Savings Program 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:
Exeltis Women's Health Savings Program
c/o Connective Rx
200 Jefferson Park, Whippany, NJ 07981

Please allow 6-8 weeks to receive your reimbursement. Reimbursements are subject to Program Terms, Conditions, and Eligibility Criteria.

GLUE INDICATION FOR POCKET

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