This information is intended for US consumers only.

HOW TO RECEIVE THE REBATE FOR MAIL-ORDER PRESCRIPTIONS FOR YOUR BRILINTA 60-MG OR 90-MG TABLETS

You may pay as little as $5 per 90-day supply for as long as your doctor prescribes it,*

if you have commercial insurance and if you receive your prescriptions through mail order.

Commercially insured patients: Eligible patients can save on out-of-pocket costs that exceed $5 (up to a $600 savings limit) on each 90-day supply.* Patients who remain eligible are automatically reenrolled.*

Cash-paying patients: Eligible patients can save up to $300 off each 90-day supply.* Patients who remain eligible are automatically reenrolled.*

*Individual out-of-pocket costs may vary. Subject to eligibility rules below; restrictions apply.

FOLLOW THESE SIMPLE STEPS

- ☐ Fill a prescription through your mail-order pharmacy for a 90-day supply of BRILINTA.
- ☐ Fill out and sign the form on the next page.
- ☐ Mail the completed form **along with the Mail-Order Pharmacy Receipt** (either the original or a copy) that came with your 90-day supply of BRILINTA. Forms submitted without the receipt are not valid and will not be eligible for reimbursement.

The Mail-Order Pharmacy Receipt should include

- Patient's name and address
- Mail-order pharmacy name
- Rx number, fill date, drug name, NDC number
- Quantity and price

Please allow at least 2 to 3 weeks to process your refund. You will receive a refund of up to $600 if your co-pay is more than $5.* Reimbursement forms must be received within one year of the fill date shown on the Mail-Order Pharmacy Receipt.

ELIGIBILITY: You may be eligible for this offer if you are insured by commercial insurance and your insurance does not cover the full cost of your prescription, or you are not insured and are responsible for the cost of your prescriptions. Patients who are enrolled in a state or federally funded prescription insurance program are not eligible for this offer. This includes patients enrolled in Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs or TriCare, and patients who are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. If you are enrolled in a state or federally funded prescription insurance program, you may not use this savings card even if you elect to be processed as an uninsured (cash-paying) patient. This offer is not insurance, is restricted to residents of the United States and Puerto Rico, and to patients over 18 years of age.

TERMS OF USE: Eligible commercially insured patients with a valid prescription for BRILINTA® (ticagrelor) tablets who present this savings card at participating pharmacies will pay as low as $5 per 30-day supply. $200 maximum savings limit applies; patient's out-of-pocket expense may vary. If you pay cash for your prescription, AstraZeneca will pay up to the first $100, and you will be responsible for any remaining balance, for each monthly prescription. Other restrictions may apply. Patient is responsible for applicable taxes, if any. Nontransferable, limited to one per person, cannot be combined with any other offer. Void where prohibited by law, taxed or restricted. Patients, pharmacists, and prescribers cannot seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this offer. AstraZeneca reserves the right to rescind, revoke, or amend this offer, eligibility and terms of use at any time without notice. This offer is not conditioned on any past, present or future purchase, including refills. Offer must be presented along with a valid prescription at the time of purchase. For additional details about this offer, please visit www.brilinta.com. If you have any questions regarding this offer, please call 1-800-422-5604.

BY USING THIS CARD, YOU AND YOUR PHARMACIST UNDERSTAND AND AGREE TO COMPLY WITH THESE ELIGIBILITY REQUIREMENTS AND TERMS OF USE.

Pharmacist Instructions for a Patient with an Eligible Third Party:
For Commercially Insured/Covered Patients: Submit the claim to the primary Third-Party Payer first, then submit the balance due to **Change Healthcare** as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 8. The patient is responsible for the first $5 and the card pays up to the next $200 per 30-day supply; patient's out-of-pocket expenses may vary. 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 (eg, 1) is required. The card will cover up to $100 per 30-day supply. Reimbursement will be received from **Change Healthcare**. Patients enrolled in a state or federally funded prescription insurance program may not use this savings card.

Valid Other Coverage Code required. For any questions regarding **Change Healthcare** online processing, please call the Help Desk 1-800-422-5604.

Please read the Medication Guide and full Prescribing Information, including Boxed WARNINGS for BRILINTA 60-mg and 90-mg tablets, at www.BRILINTAPI.com

BRILINTA®
ticagrelor tablets

MAIL-ORDER REBATE FORM FOR BRILINTA

TO AVOID DELAYS

- ☐ **Be sure to send in both this completed form and your Mail-Order Pharmacy Receipt (the original or a copy).**
- ☐ Print neatly if you are filling out this form by hand.

FILL OUT THIS SECTION

Patient's full name _____ Date of birth ___mm___/___dd___/___yy___

Address _____

City _____ State _____ ZIP _____

E-mail (optional) _____ Phone (____) _____

"I, _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the co-payment or out-of-pocket expenses requested for reimbursement were actually incurred."

"I, _____, certify that my prescription was not purchased under Medicaid, Medicare, or a similar federal or state insurance program; and that I am not Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees."

Patient's signature _____ Date _____

Mail your completed form and original or photocopied Mail-Order Pharmacy Receipt to

AZ Claims Processing Dept
PO Box 2355
Morristown, NJ 07962

Please read the Medication Guide and full Prescribing Information, including Boxed WARNINGS for BRILINTA 60-mg and 90-mg tablets, at www.BRILINTAPI.com

BIN# 4682
PCN# CN
GRP# EC57006519
ID# 4159966516

You may report side effects related to AstraZeneca products by clicking here.

If you have questions or would like additional information, please click here or call **1-888-512-7454.**

If you cannot afford your medication, AstraZeneca may be able to help. For more information, please visit **AstraZeneca-US.com.**

BRILINTA® ticagrelor tablets

AstraZeneca