The EUFLEXXA Commitment Refund Form

This form is for reimbursement of up to $100 for your out-of-pocket costs associated with your purchase of EUFLEXXA. You must meet all terms and conditions to be eligible to receive a refund through this program. Ferring Pharmaceuticals in its sole discretion reserves the right to review your eligibility prior to issuing your refund.

TO RECEIVE YOUR REFUND:
- Print, complete, and submit refund form
- **Attach** Explanation of Benefits for each injection from your insurance company
- **Attach** receipt(s) reflecting payment towards your copay amount for EUFLEXXA
- Fax to: The EUFLEXXA Commitment at 866-383-5392

Please fill out and submit ALL of the following information:

1. First Name: _____
2. Last Name: _____
3. Date of Birth: _____
4. Address
    a. Street: _____

       _____
    b. City: _____
    c. Zip: _____
5. Patient Phone: _____
6. Physician Name: _____
7. Physician Address: _____
8. Physician Phone: _____
9. Injection Dates (MM/DD/YYYY):
    a. First Injection: _____
    b. Second Injection: _____
    c. Third Injection:_____

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10. Total out-of-pocket amount: $_____

You'll receive a refund based on the out-of-pocket amount you've paid. Maximum refund amount will not exceed $100.00. The refund amount received may vary from the price entered here if you have incorrectly entered the amount paid (as reflected on your Explanation of Benefits). Only the amount for the injection administration and/or EUFLEXXA will be reimbursed – office visit copay is ineligible for a refund through this program.

11. Physician Signature Required: _____

By signing, I certify that _____ (patient's name) has undergone only one treatment regimen with EUFLEXXA and the dates of the injections as listed above are accurate.

Patient Authorization: By signing and submitting this form, I am giving my permission for the disclosure and use of my personal health information to Ferring Pharmaceuticals Inc. ("Ferring") and its agents for purposes (i) of determining my eligibility for the refund program; (ii) administering my refund; and (iii) of internal business purposes, including quality control and research. I understand that Ferring or its agents may communicate with my health care provider and insurers to determine my program eligibility. I understand that I am not required to sign this form and provide my consent, however, I cannot take part in the refund program if I do not do so. I understand that I may cancel my permission for Ferring and its agents to use my health information at any time, but if I do so, I can no longer participate in the refund program. Once my cancellation request is processed, Ferring and its agents will not be able to use my health information going forward, but my cancellation will have no effect on information that I have previously provided. I am granting my permission for use of my personal health information for a period of three years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this form is subject to re-disclosure by the program and will no longer be protected by HIPAA.

By signing below, I certify that:
(a) the information provided for this refund request is complete and accurate and the out of pocket expenses set forth above were actually incurred;
(b) I have met all of the eligibility requirements for the program and I am not enrolled in any federal or state healthcare program, including without limitation Medicare, Medicaid, Department of Veterans Affairs healthcare program, TRICARE and any federal or state employee benefit program;

Patient Signature: _____

Patient Name (Printed): _____

Date: _____

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Offer Terms and Conditions:

- This offer is not valid for any other Ferring Pharmaceuticals Inc product. Fax-in only. No mail, phone, or emailed requests will be honored
- Ferring Pharmaceuticals is not responsible for lost, late, damaged, misdirected, incomplete or illegible submissions
- The value of this refund may not exceed the amount of patient's responsibility (copay) for the prescription. Maximum refund amount is $100.
- Offer limited to cash-paying or commercial US residents who received three (3) injections of EUFLEXXA within 21 days as indicated i.e one injection a week for 3 weeks and are undergoing their first EUFLEXXA treatment regimen.
- Refund claims must be received between 10 and 14 weeks after the last injection. All claims must be received by December 31, 2023.
- Limit one refund per eligible patient
- Ferring Pharmaceuticals reserves the right to cancel, modify, or rescind the program at any time
- The patient responsibility (copay) for the injection administration and/or EUFLEXXA must be isolated on the claim. Office visits or other ancillary costs included in patient's responsibility are excluded from refund amount
- This offer is void where prohibited or restricted by law. Offer not valid for prescriptions and/or services reimbursed in whole or in part by any federal or state healthcare program, including without limitation Medicare, Medicaid, Department of Veterans Affairs healthcare program, TRICARE and any federal or state employee benefit program
- Please retain copies of the materials you submit. All submissions become the property of a Ferring Pharmaceuticals contracted third-party vendor
- Patient must fully complete and follow instructions as stated on the claim form
- Tampering with, altering, or falsifying payment information constitutes fraud
- Please allow 4-6 weeks for delivery of refund check. Refund check will be issued in US dollars