endo ADVANTAGE™ Committed to Access

Copay Assistance Program Rebate Form

By accepting this offer, you agree to report the value received under this offer to any health insurer or other third party paying for any part of your AVEED® (testosterone undecanoate) injection prescription if you are required to do so by benefit terms, contract, or law. This offer is not valid for prescriptions reimbursed in whole or in part by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, similar federal or state programs, or where otherwise prohibited by law. By accepting this offer, you agree that Endo Pharmaceuticals Inc. or those working on its behalf may contact your doctor to verify information about treatment that is relevant to verifying your eligibility for this offer. This offer is only valid for doses of AVEED® administered in the US. This offer is valid for the out-of-pocket cost for the dose of AVEED® only. Offer is not valid for any other products or other out-of-pocket costs (for example, office visit charges, office visit copays, or injection/administration costs) even if those costs are associated with the administration of a dose of AVEED®. The selling, purchasing, trading, or counterfeiting of this offer is prohibited. Endo Pharmaceuticals Inc. reserves the right to rescind, revoke, or amend this offer without notice. By participating, you understand and agree to comply with the terms and conditions of this offer as set forth above. Please see AveedUSA.com for additional patient eligibility requirements.

Practice Billing Information (all fields are required)

Physician/ Practice Name _____ Address _____

City _____ State _____ ZIP _____

Contact Phone Number _____ Email Address _____

Patient Information – Must Be Signed by Patient (all fields are required)

First Name _____ Middle _____ Last Name _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____ Date of Birth _____

Phone _____ Email Address _____

Injection # (Which injection is this? For example, 1st, 2nd, 3rd, 4th, etc) _____

Claim Information

Patient out-of-pocket amount _____

Patient Certification and Consent – Must Be Signed by Patient

By signing below, I acknowledge and attest to the following: (1) The AVEED® Copay Assistance Program assists with out-of-pocket costs related to AVEED® (drug only). No other expenses are covered by this program; (2) A failure by me or my physician to follow the program rules may void my participation in the program; (3) I am not covered by a federal- or state-funded health insurance program; (4) I have been diagnosed with hypogonadism (low testosterone).

Patient Signature: _____

Please remit assistance to (select 1):

- ☐ Patient
- ☐ Practice/Physician (If Practice option is selected, payment will be made in accordance with the Practice Information provided above.)

Assignment of Benefits

I hereby assign all financial assistance available to me through the AVEED® Copay Assistance Program to be payable to Practice listed above. Practice will receive all financial assistance, on my behalf, through the AVEED® Copay Assistance Program and will credit my account accordingly.

Patient Signature: _____ Date _____

Reimbursement Process

Complete this form in its entirety and submit it with the following items:

- For insured patients: Attach a copy of the Explanation of Benefits (EOB) specifying total price of AVEED® and billing statement indicating the amount you paid for AVEED®.
- For cash-paying patients: Attach the billing statement indicating the amount you paid for AVEED®.

Forms submitted without these items will not be valid and will not be eligible for processing. Please allow 4-6 weeks for processing. Submit reimbursement claim and attachments via mail, fax, or online:

Mail: AVEED® Copay Assistance Program
680 Century Point
Suite 1000
Lake Mary, FL 32746

Fax: 1-800-872-2056

Online: AveedUSA.com/PatientSavingsProgram

For questions about the AVEED® Copay Assistance Program, the program offer, or this form, please call 1-800-381-2638.

Please click here for full Prescribing Information, including Boxed Warning and Medication Guide for patients.

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Rx Only

AV-05179/November 2019 www.AveedUSA.com 1-800-462-ENDO (3636)