



**Intrarosa®**  
Prasterone

**SAVINGS PROGRAM**

\*Eligible commercially insured patients pay no more than \$35 copay for each 28-day supply of INTRAROSA for up to 12 months. Limitations apply.

**PAY NO MORE THAN**  
**\$35\***  
**COPAY**

**BIN#** 019158  
**PCN#** CNRX  
**GRP#** AC36701007  
**ID#** 19347674763

Offer valid on up to 12 uses for commercially insured patients with a valid prescription for INTRAROSA. A valid prescriber ID# is required on the prescription. See full terms and conditions on the back of this card. See full Prescribing Information at [INTRAROSA.com](http://INTRAROSA.com).

Eligible commercially insured patients pay no more than \$35 copay for each 28-day supply of INTRAROSA for up to 12 months. Limitations apply. Each copay card may be used once every 28 days for up to 12 uses. A valid prescriber ID# is required on the prescription. Any remaining out-of-pocket expense will be the patient's responsibility.

**Patient Instructions:** In order to redeem this offer, you must have a valid prescription for INTRAROSA. Follow the dosage instructions given by the doctor. This offer may not be redeemed for cash and is not insurance. By using this offer, you are certifying that you meet the eligibility criteria and will comply with the terms and conditions described in the Restrictions section below. Patients with questions about the INTRAROSA Savings offer should call **1-844-492-9898**.

**Pharmacist:** When you apply this offer, you are certifying that you have not submitted a claim for reimbursement under any federal, state, or other governmental programs for this prescription. Participation in this program must comply with all applicable laws and regulations as a pharmacy provider. By participating in this program, you are certifying that you will comply with the terms and conditions described in the Restrictions section below.

**Pharmacist Instructions for a Patient With an Eligible Third-Party Payer:** Submit the claim to the primary Third-Party Payer first, then submit the balance due to **Argus** as a Secondary Payer as a copay only billing using **BIN# 019158** and a valid Other Coverage Code (eg, 8). Eligible commercially insured patients pay no more than \$35 copay for each 28-day supply of INTRAROSA for up to 12 months. Limitations apply. Reimbursement will be received from **Argus**. Valid Other Coverage Code required. For any questions regarding **Argus** online processing, please call the Help Desk at **1-844-373-0987**.

**Restrictions:** This offer is valid in the United States and Puerto Rico for commercially insured patients 18 years of age or older. Offer not valid for prescriptions reimbursed under Medicaid, Medicare, TRICARE, VA, DOD, or other federal or state health programs (such as medical assistance programs). If the patient is eligible for drug benefits under any such program, the patient cannot use this offer. By using this offer, the patient certifies that he or she will comply with any terms of his or her health insurance contract requiring notification to his or her payer of existence and/or value of this offer. It is illegal to (or offer to) sell, purchase, or trade this offer. This offer is not transferable and is limited to one offer per person. Not valid if reproduced. Void where prohibited by law. Program managed by ConnectiveRx on behalf of AMAG Pharmaceuticals, Inc. **The parties reserve the right to rescind, revoke, or amend this offer without notice at any time.**



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