$0 Copay* for most eligible **covered** patients

$25* for most eligible **uncovered** patients

RxBIN: **025706**
RxPCN: **IFX**
GRP: **MP01**
ID: **MAYN2023**

nextstellis®
(drospirenone and estetrol tablets)
3 mg/14.2 mg

mayne pharma

*Restrictions and limitations apply. Please see reverse side for Terms, Conditions, and Eligibility Criteria.

Maximum limitations apply. By using this card, you acknowledge that you meet the Program Terms, Conditions, and Eligibility Criteria.

If your pharmacy is having trouble processing the card, please show the "To the Pharmacist" or call 1-888-927-3499 for the pharmacist to speak to the copay card support team.

Program Terms, Conditions, and Eligibility Criteria:

1. THIS COPAY CARD PROGRAM IS NOT HEALTH INSURANCE. **2.** To be eligible for this Copay Card program, a patient must have a commercial insurance plan, which may be a healthcare exchange plan, that covers a valid NEXTSTELLIS prescription at the time the prescription is filled and dispensed by the pharmacist. **3.** This offer is not valid (a) where prohibited by law, (b) for a patient enrolled in federal or state-funded programs (including, but not limited to, TRICARE, Medicare, Medicaid, Medicare Advantage, Part D, Medigap, VHA, DOD, IHS, or state pharmaceutical assistance programs), (c) for a cash-paying patient, (d) for a patient with private indemnity or a HMO insurance plan that fully reimburses prescription costs, or (e) for a Medicare-eligible individual enrolled in an employer-sponsored health plan or retiree prescription drug benefit program. **4.** Eligible patients may incur out-of-pocket costs which may vary for each eligible patient. **5.** Restrictions and limitations may apply, including, without limitation, maximum reimbursement limits. **6.** A patient must meet any applicable commercial insurance deductible requirements and Prior Authorization submission requirements as determined by the patient's insurer. **7.** This offer is not transferable; selling, purchasing, trading, or counterfeiting this Copay Card is prohibited by law. **8.** A patient may not seek reimbursement for the value received from the Copay Card program from any third-party payers, including a flexible spending accounts or a health care savings account. **9.** This offer expires on December 31, 2025, and valid prescriptions must be filled before this offer expires. **10.** Mayne Pharma reserves the right to rescind, revoke or amend this offer without notice. **11.** This offer is valid only in the United States and at participating retail pharmacies. **12.** This offer is void if prohibited by law, taxed, or restricted. **13.** Pricing is subject to change. **14.** InfinityRx manages this Copay Card program on behalf of Mayne Pharma.

By redeeming this Copay Card, you acknowledge and confirm that (a) you are an eligible patient and (b) you understand, and will comply with, the Program Terms, Conditions, and Eligibility Criteria of this offer. For questions about this Copay Card offer please call InfinityRx at 1-888-927-3499.

For the Pharmacist: By submitting a claim to redeem this Copay Card offer, you (the pharmacist) certify that no claim has been, or will be, submitted for reimbursement for this prescription under any federal, state, or other government-funded programs or any other payer for which this offer is not valid. Valid Other Coverage Code is required. Eligible reimbursement will be made by InfinityRx. For any questions regarding online processing, please call the InfinityRx Help Desk at 1-888-927-3499.

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