



The processing information is:

RXBIN 610600
PCN AS
RxGroup 037
ID # 03700854632

Pharmacy help desk: **877-274-3244**

Save with Novadoz. Here's How:

PATIENT INSTRUCTIONS:

1. Present this card or BIN, Group and ID numbers to your pharmacist along with a valid prescription.
2. Eligible, commercially insured patients may receive their Novadoz Pirfenidone Tablets and Deferasirox Oral Granules monthly prescription for \$0*.
3. If you have any questions, please feel free to call Pharmacy help desk 877-274-3244

VALID ON THE FOLLOWING NDCS ONLY

72205-0176-30 Deferasirox Oral Granules 90mg	72205-0181-36 Pirfenidone 267mg 90 ct
72205-0075-30 Deferasirox Oral Granules 180mg	72205-0181-26 Pirfenidone 267mg 270 ct
72205-0076-30 Deferasirox Oral Granules 360mg	72205-0182-90 Pirfenidone 801mg 90 ct

To Patient: Commercially insured patients can use this copay card to reduce out-of-pocket expenses on eligible prescriptions filled with Novadoz Pirfenidone Tablets and Deferasirox Oral Granules. Mention this offer to your pharmacy along with a valid prescription for an FDA-approved use. This offer is valid for a maximum savings of \$500 per monthly prescription fill, and \$6,000 per calendar year. By using this offer, you acknowledge that you meet the Eligibility Criteria and will comply with the Terms and Conditions set forth below.

To Pharmacist: Offer valid for SECONDARY claims only. Process a Coordination of Benefits (COB/split bill) claim using the patient's prescription insurance for the PRIMARY claim. Submit the SECONDARY claim to AlphaScrip under BIN: 610600. Patient will receive a maximum of \$500 off per monthly prescription fill for their out-of-pocket cost.

Eligibility Criteria/Terms & Conditions:

1. This offer is only good for use by patients with a valid prescription for an eligible product with an approved indication at the time the prescription is filled and dispensed to the patient.
2. This card is not valid for use by patients enrolled in Medicare, Medicaid, or other federal or state programs (including any state pharmaceutical assistance programs), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. This offer is not valid for cash-paying patients.
3. Maximum savings limit applies; patient out-of-pocket expense may vary. Offer applies only to prescriptions filled before the program expires.
4. Novadoz Pharmaceuticals LLC reserves the right to rescind, revoke, or amend this offer without notice. Offer good only in the USA, including Puerto Rico, at participating pharmacies. This offer is not valid for residents of Massachusetts. Void if prohibited by law, taxed, or restricted.
5. This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. This offer is not health insurance.
6. By redeeming this card, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.

*Max benefit of \$500 per monthly prescription fill and \$6,000 per calendar year