Your mail-order patients may be eligible to save on **CRESTOR***

If your commercial insurance plan offers a mail-order option, and your co-pay is more than **$3** a month, you may be eligible to save on **CRESTOR**.*

Eligible patients can get a mail-order prescription of CRESTOR for as low as

$3 FOR A 3-MONTH SUPPLY

or $3 for a 2-month supply or $3 for a 1-month supply*

Instructions

1. Fill a prescription at your mail-order pharmacy for CRESTOR.
2. If eligible, fill out completely, and sign this form.
3. Mail the completed and signed form along with the original or photocopy of the Mail-order Pharmacy Receipt that you received with your supply of CRESTOR (cash register receipts are not acceptable). Forms submitted without completion or without these items will not be valid and therefore will not be eligible for reimbursement.

The Mail-order Pharmacy Receipt should include

- Patient name and address
- Mail-order pharmacy name, address, and phone number
- Prescription number or Rx number, fill date, drug name, strength, NDC number
- Quantity, price, and/or co-pay amount paid

Please allow at least 6 to 8 weeks to process your refund.
*Individual out-of-pocket costs may vary. Please see eligibility on back for details. Other restrictions may apply. Reimbursement forms must be received within one year of the fill date shown on the Mail-order Pharmacy Receipt.

CRESTOR® rosuvastatin calcium

For mail-order pharmacy prescriptions only. Provide the information and read and sign below to receive your refund if eligible.

Patient's full name _____ Date of birth (mm/dd/yy) _____/_____/_____

Address _____

City _____ State _____ ZIP _____

Phone _____ E-mail (optional) _____

CRESTOR Savings Card Group #EC57002153 **CRESTOR Savings Card ID #413770945620**

I, _____, certify that my prescription was not purchased under Medicaid, Medicare, or a similar federal or state insurance program; that I am not Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees.

I, _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the co-payment or out-of-pocket expenses requested for reimbursement were actually incurred.

Patient's signature _____ Date _____

Mail your completed form and original or photocopied Mail-order Pharmacy Receipt to:
Claims Processing Dept for AstraZeneca, PO Box 7017, Bedminster, NJ 07921

ELIGIBILITY AND OFFER RESTRICTIONS

Patient Eligibility for Mail-order Rebate: You may be eligible for this offer if you are insured by commercial insurance and your insurance does not cover the full cost of your prescription, or you are not insured and are responsible for the cost of your prescriptions.

Patients who are enrolled in a state or federally funded prescription insurance program are not eligible for this offer. This includes patients enrolled in Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs or TriCare, and patients who are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. If you are enrolled in a state or federally funded prescription insurance program, you may not use this rebate form even if you elect to be processed as an uninsured (cash-paying) patient.

This offer is not insurance and is restricted to residents of the United States and Puerto Rico, and patients over 18 years of age. This offer is valid for prescription purchased through a mail-order pharmacy.

Terms of Use: Eligible commercially insured patients with a valid prescription for CRESTOR® (rosuvastatin calcium) Tablets will pay $3 for a 30-, 60-, or 90-day supply, subject to a maximum savings of $65 per 30-day supply, $130 per 60-day supply, or $195 per 90-day supply. Eligible cash-paying patients will receive up to $65 in savings on out-of-pocket costs per 30-day supply. Offer good for 12 uses; each 30-day supply counts as 1 use. This offer is good for a 30-day supply, 60-day supply, or 90-day supply, and expires 14 months from the date of first use. Other restrictions may apply. Patient is responsible for applicable taxes, if any. If you have any questions regarding this offer, please call **1-844-828-3233**.

Nontransferable, limited to one per person, cannot be combined with any other offer. Void where prohibited by law, taxed, or restricted. Patients, pharmacists, and prescribers cannot seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this offer. AstraZeneca reserves the right to rescind, revoke, or amend this offer, eligibility, and terms of use at any time without notice. This offer is not conditioned on any past, present, or future purchase, including refills. A valid prescription for CRESTOR must be presented at the time of purchase.

BY USING THIS REBATE FORM, YOU UNDERSTAND AND AGREE TO COMPLY WITH THESE ELIGIBILITY REQUIREMENTS AND TERMS OF USE.

Program managed by PSKW, LLC, on behalf of AstraZeneca.

Mail your completed form and original Mail-order Pharmacy Receipt to:

Claims Processing Dept for AstraZeneca
PO Box 7017
Bedminster, NJ 07921

CRESTOR®
rosuvastatin calcium

AstraZeneca