HERE'S HOW TO SAVE!

Save on MENOPUR

- Complete the form below and submit your MENOPUR receipts to receive your rebate.
  - Cash-paying patients are eligible to receive a $200 rebate for out-of-pocket costs of MENOPUR.
  - Insured patients may receive up to a $200 rebate for out-of-pocket co-pay or co-insurance costs.
- Applies to Bloom box purchases made after January 12, 2018.
- Checks will be mailed within 45 days of receipt of your completed form and receipts.

Costs reimbursed in whole or in part by Medicaid, Medicare, federal or state programs (including any state exchange established by a state government or the federal government) are not eligible for rebate. Ferring Pharmaceuticals Inc. in its sole discretion reserves the right to review your eligibility prior to issuing payment. Rebate cannot be combined with any other MENOPUR discount or savings program. This program may be rescinded, revoked or modified at any time.

Massachusetts residents are eligible to participate in the Rebate Program if an individual purchases 30 or more vials of MENOPUR (menotropins for injection) and 42 inserts of ENDOMETRIN (progesterone) Vaginal Insert as part of a single treatment cycle.

Menopur® (menotropins for injection)

MAIL-IN REBATE FORM

Mail this rebate form and your receipts to:
Envision - Rx initiatives
P.O. Box 150970, Ogden, UT 84415

Patient Information – Fill out the form below and return:

PRACTICE NAME ______________________________

FIRST NAME ______________ MIDDLE ________ LAST ______________

ADDRESS 1 ______________________________

ADDRESS 2 ______________________________

CITY ______________ STATE ________ ZIP ______________

PHONE ______________ E-MAIL ______________ DATE OF BIRTH ______________

Purchase Information – Attach pharmacy receipt(s) as proof of purchase. Rebate form must be returned within 45 days of purchase in order to receive your rebate.

	Quantity Purchased	Amount Paid
MENOPUR	______________ vials	______________

By signing below, I certify that the information provided for this reimbursement request is complete and accurate to the best of my knowledge, and the out-of-pocket expenses requested for reimbursement were actually incurred.

This completed form contains personal health information that is protected by law, such as your name, address, e-mail,and date of birth. By signing this form, you authorize Ferring Pharmaceuticals or its agents to use your personal health information and medical information solely to verify your eligibility to receive a rebate and communicate the status to you and your healthcare professional. Ferring will not otherwise sell, distribute, or exchange your personal health information or medical information with any third parties.

Patient signature: ______________________________ Date: ______________

☐ By checking this box, you certify that you are a non-Massachusetts resident that received a Bloom box as support through your IVF journey.

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