

IVFGREENLIGHT

READY. SET. SAVE.

Savings available for cash-paying patients with IVF Greenlight

- 50% off BRAVELLE® (urofollitropin for injection, purified)
- 15% off MENOPUR® (menotropins for injection)
- 15% off ENDOMETRIN® (progesterone) Vaginal Insert
- 15% off NOVAREL® (chorionic gonadotropin for injection, USP)

How to qualify

- Pay cash for the full cost of your medication
- Purchase at least 10 vials of BRAVELLE and 10 vials of MENOPUR
 - Purchase of ENDOMETRIN and NOVAREL is optional. No minimum requirement
- Purchase must be made at a participating IVF Greenlight Pharmacy. See complete list of pharmacies at www.IVFGreenlight.com
- Applies to purchases made on or after August 11, 2014

Claim your rebate in 3 simple steps

1. Fill your prescription at an IVF Greenlight Pharmacy
2. Complete the Enrollment Form on the following page and attach valid pharmacy receipt(s) for purchase of BRAVELLE and MENOPUR, as well as receipt(s) for optional purchase of ENDOMETRIN and/or NOVAREL
 - Valid receipt(s) must include product name(s), quantity, NDC number(s), prescription number, pharmacy name, date purchased, your name, and amount paid
3. Mail completed Enrollment Form and accompanying pharmacy receipt(s) within 30 days of BRAVELLE and MENOPUR purchase to:

IVF Greenlight Redemption Center
930 Harvest Drive
Suite 199
Blue Bell, PA 19422

You will receive a rebate check in the mail within 30 days following receipt of Enrollment Form.

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ENROLLMENT FORM

This form is for reimbursement of your out-of-pocket expenses associated with the purchase of BRAVELLE, MENOPUR, ENDOMETRIN, and/or NOVAREL. Costs reimbursed in whole or in part by private insurance, Medicaid, Medicare, federal, or state programs (including any state prescription drug programs, or any qualified health plan purchased through a health insurance exchange established by a state government or the federal government) are not eligible for rebate. Ferring Pharmaceuticals in its sole discretion, reserves the right to review your eligibility prior to issuing payment. For the full terms and conditions of the program, please visit www.IVFGreenlight.com.

Physician Information

PRACTICE NAME _____

FIRST NAME _____ MIDDLE _____ LAST _____

ADDRESS 1 _____ ADDRESS 2 _____

CITY _____ STATE _____ ZIP _____

PHONE _____ NURSE E-MAIL _____

Patient Information

FIRST NAME _____ MIDDLE _____ LAST _____

ADDRESS 1 _____ ADDRESS 2 _____

CITY _____ STATE _____ ZIP _____

PHONE _____ E-MAIL _____ DATE OF BIRTH _____

Purchase Information – attach pharmacy receipt(s) to validate

	Quantity Purchased	Amount Paid
BRAVELLE	_____ vials	_____
MENOPUR	_____ vials	_____
ENDOMETRIN	_____ inserts	_____
NOVAREL	_____ 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 under the IVF Greenlight Program 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: _____