Anzupgo®
(delgocitinib) cream 2%

Copay Reimbursement Form

If you have commercial insurance and have paid your full copay within the last 90 days, you may be eligible for reimbursement of certain product-specific copay, coinsurance, or deductible costs for a prescription of ANZUPGO (delgocitinib) under the ANZUPGO Copay Program.

Reimbursement is subject to program terms, conditions, and eligibility rules. Payment of the reimbursement is also subject to verification. Submission of this form is not a guarantee of payment.

IMPORTANT REMINDER: Make sure you've enrolled in the ANZUPGO Copay Program before submitting this form. Scan the QR code to the right to enroll.

PATIENT INFORMATION

First Name _____ **Middle Initial** ____ **Last Name** _____ **Date of Birth** (MM/DD/YYYY) _____

Address _____

Address 2 _____

City _____ **State** _____ **ZIP Code** _____

Phone Number _____ **Email Address** _____

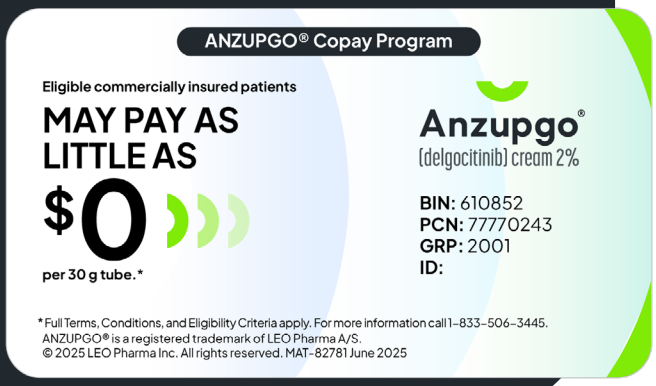
REIMBURSEMENT PROCESS

Please fill out all fields on this form completely and include the items listed below.
Forms submitted without these items will not be eligible for reimbursement.
Forms will generally take up to 7 to 10 business days to process.

- **Attach a copy of your ANZUPGO prescription label** (prescription receipt from the pharmacy that includes name and address of pharmacy, dosing, and days' supply)
- **Fill in the following information** in the boxes below, or provide a copy of the front of your copay card. See image to the right for reference

  Member ID:

  Include patient certification and signature (see below)



SUBMIT REIMBURSEMENT REQUEST AND ATTACHMENTS VIA MAIL OR FAX TO:

Mail: ANZUPGO Copay Program, 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560 **Fax:** 1-866-207-7781

I, (Patient/Caregiver/Legal Representative) _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the product-specific copay, coinsurance, or deductible expenses requested for reimbursement were actually incurred. My prescription for ANZUPGO was not paid in whole or in part (either directly or through dependent coverage) by Medicare (including Medicare Part D), Medicaid, VA, DOD, TRICARE, CHIP, or other federal or state programs including any state pharmaceutical assistance programs.

Patient Name (Print) _____

Legal Representative Name (Print) _____

Patient/Legal Representative Signature _____ **Date** _____

If you have questions about the ANZUPGO Copay Program or you wish to discontinue your participation, please contact us at 1-833-506-3445.

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