Program Terms, Conditions, and Eligibility Criteria:

1. THIS IS NOT HEALTH INSURANCE. Eligible patients must have a commercial medical or prescription insurance plan, be uninsured, or have an insurance plan that does not cover the prescription. **2.** Deductible and Prior Authorization requirements may apply. Patients must meet applicable commercial insurance deductible requirements and Prior Authorization submission requirements as determined by their commercial insurers. **3.** This offer is valid only for eligible patients and is good for use only with a valid prescription for IMVEXXY at the time the prescription is filled by the pharmacist and dispensed to the patient. **4.** Depending on insurance coverage, most covered, insured, eligible patients will pay $35 for their IMVEXXY prescription. **5.** Insured, eligible patients may incur out-of-pocket costs. Maximum reimbursement limits apply; patient out-of-pocket expenses may vary. **6.** This Copay Savings offer is not valid for use by patients enrolled in TRICARE, Medicare, Medicaid, Medicare Advantage, Medicare Part D, Medigap, VHA, DOD, IHS any other federal or state-funded programs (including any state pharmaceutical assistance programs), or private indemnity or HMO Insurance plans that reimburse the patient for the entire cost of the prescription drugs. Patients may not use this offer if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. **7.** Patients who move from commercial to federally funded or state-funded insurance will no longer be eligible for the Program. **8.** This Copay Savings Card offer is not transferable. Selling, purchasing, trading or counterfeiting this Copay Savings Card offer is prohibited by law. **9.** Patients may not seek reimbursement for the value received from the Copay Savings Card from any third-party payers, including flexible spending accounts ("FSAs") or healthcare savings accounts ("HSAs"). **10.** All prescriptions must be filled before the program expires on 12/31/24. **11.** Mayne Pharma reserves the right to rescind, revoke or amend this offer without notice. **12.** Offer good only in the USA at participating retail pharmacies. **13.** Void if prohibited by law, taxed, or restricted. **14.** Restrictions and limitations apply. Out-of-pocket cost may vary. Pricing is subject to change.

By redeeming this Copay Savings Card, you, the patient, parent or guardian, acknowledge that you are a commercially insured, eligible patient and that you understand and agree to comply with the Terms and Conditions of this offer.

For questions about this Copay Savings Card offer please call Apollo Care at 347-442-7919.

Pharmacist Instructions for a patient with an eligible third-party payor: When you submit a claim to redeem this Copay Savings Card offer from Mayne Pharma, you certify that you have not submitted and will not submit a claim for reimbursement under any federal-, state-, or other government-funded programs for this prescription. Valid Other Coverage Code is required. Reimbursement will be received from Change Healthcare. For any questions regarding online processing, please call the Help Desk at 1-800-433-4893. Program manage by Apollo Care on behalf of Mayne Pharma.

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