

Rebate Form

Submit this form if your pharmacy can't process your ICOTYDE withMe Savings Program Virtual Payment Card.

STEP 1 The patient must be enrolled in the ICOTYDE withMe Savings Program. The patient can enroll online at Account.JNJwithMe.com.

STEP 2 The patient or the patient's legally authorized representative must use the savings card to complete the information below and sign the form.

STEP 3 Include a copy of the pharmacy receipt. A valid receipt will include the patient's name, medicine name, date, and amount paid for ICOTYDE. If the receipt includes a prescription number but does not include the medicine name, also include a copy of the prescription label from the medicine carton.

STEP 4 Mail this signed form along with the pharmacy receipt and prescription label from the medicine carton, if required, to the address below. Eligible patients will receive a rebate check in about three weeks. Rebate requests must be submitted within 365 days of the prescription fill date.

*See [Terms](#) and [Privacy Statement](#).

Patient Information (Required)

The information you provide will only be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers to provide benefits to the patient related to the activation and use of the ICOTYDE withMe Savings Program card. If you want to stop receiving this information or service, you may withdraw from the program by calling 866-708-8987. Our [Privacy Statement](#) governs the use of the information you provide.

By providing consent, you agree to the collection and use of your/the patient's Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Statement, including to personalize the information you receive, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your/the patient's SPI.

Name _____

Date of Birth (MM/DD/YYYY) _____ Sex Male Female

Address _____

City _____ State _____ ZIP _____

Email _____ Phone _____

11-digit Savings Program ID # found on the front of the card _____

This program is only for people age 12 or older using commercial or private health insurance who must pay an out-of-pocket cost for their prescribed ICOTYDE. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration. You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

You must meet the program requirements every time you use the Savings Program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Program participants are subject to an annual maximum benefit. Program benefits are set at the discretion of J&J and may change without notice.

To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program, if required. By using the Savings Program, you confirm that you have read, understood, and agree to the program requirements, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. **REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL.** Use of this program is subject to the program requirements, which can be found at ICOTYDEwithMeSavings.com.

By signing, dating, and submitting this form, you confirm that the **patient**:

- **Has enrolled in the ICOTYDE withMe Savings Program and has their Savings Program card. Note: ICOTYDE withMe cannot process this rebate form if the patient does not have their Savings Program card; and**
- Meet the program requirements of the Savings Program, which may also be found at ICOTYDEwithMeSavings.com.

PATIENT SIGNATURE _____ PATIENT NAME _____ DATE _____
If the patient cannot sign, patient's legally authorized representative must sign below (Please print)

LEGALLY AUTHORIZED REPRESENTATIVE NAME _____ BY _____
(Please print) (Signature of person signing for patient)

RELATIONSHIP TO PATIENT AND AUTHORITY TO MAKE MEDICAL DECISIONS FOR PATIENT _____

You can submit by mail:  ICOTYDE withMe Savings Program
 2250 Perimeter Park Drive, Suite 300
 Morrisville, NC 27560

OR Online:  Account.JNJwithMe.com/submit-rebate

Patient will receive a rebate check in about three weeks.

For assistance or additional information, call **866-708-8987**, Monday–Friday, 8:00 AM–8:00 PM ET or visit JNJwithMe.com/icotyde.

The support and resources provided by ICOTYDE withMe are not intended to provide medical advice, replace a treatment plan you receive from your doctor or nurse, or serve as a reason for you to start or stay on treatment.

Please read full [Prescribing Information](#) and [Patient Information](#) for ICOTYDE and discuss any questions you have with your doctor.