PAY AS LITTLE AS $25*

for your next prescription of Silenor®

*This offer will reduce your out-of-pocket cost down to as little as $25.
Minimum 30 tablet prescription required.

BIN: 610020 GROUP: 99992452 ID: 35070559310

silenor® doxepin tablets

*Attention Patient: This offer is subject to limitations. See Eligibility and Restrictions listed below.

MAIL-IN REBATE

If your pharmacist is unable to provide the savings at the time you fill your prescription, you can still take advantage of this program if eligible.

A. Complete this form with your name and address.

B. Circle the product name, date, your name, and amount paid on the original pharmacy receipt. Cash register receipt NOT accepted.

C. Mail this form, your pharmacy receipt, and a copy of your Silenor® Savings Card to:

Silenor® SAVINGS PROGRAM, 2250 PERIMETER PARK DRIVE, SUITE 300, MORRISVILLE, NC 27560

D. You should receive your check in the mail in 10-14 days.

FIRST NAME **LAST NAME**

ADDRESS **SUITE OR APT #**

CITY **STATE** **ZIP CODE**

SIGNATURE
By my signature, I certify that I meet the Eligibility and Restrictions listed below.

TO PATIENT: Present this card with your prescription for Silenor® to your pharmacist and receive savings on your copay. This offer may buy your out-of-pocket cost down to $25. Maximum program benefit will be dependent upon your insurance and the product quantity purchased. You are responsible for any cost remaining after program benefit is applied.

TO PHARMACIST: Process a Coordination of Benefits (COB) transaction using your customer's prescription insurance for the primary claim and PDM using BIN: 610020 for the secondary claim. The secondary claim will buy most out-of-pocket cost down to $25. Maximum benefit is dependent upon patient's individual insurance and product quantity purchased. This offer may be used for Silenor® 3 mg or 6 mg. Present this card back to your customer for possible future uses. This card can be used for patients who have commercial insurance as well as patients who are cash payers.

FOR PROCESSING QUESTIONS, PLEASE CALL 1-877-319-4099.

ELIGIBILITY AND RESTRICTIONS: This savings card will allow most patients to pay as little as $25 for their Silenor® prescriptions. Patients with high copay plans or prescription plans based on an annual deductible may have additional responsibility. Maximum benefit provided is dependent upon patient's individual prescription plan and product quantity purchased. There is no redemption limit. Card is valid for insured patients and cash payers. Card is valid only in the USA. This card is not valid if your prescription is paid/partially paid by Medicaid, Medicare, Federal or State healthcare programs. PERNIX Therapeutics Holdings, Inc. reserves the right to rescind, revoke, or amend this card without notice. Void where prohibited by law.

PERNIX THERAPEUTICS