

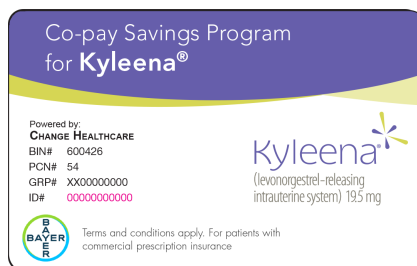
Kyleena®
(levonorgestrel-releasing
intrauterine system) 19.5 mg

Mirena®
(levonorgestrel-releasing
intrauterine system) 52 mg



Co-pay Savings Program for Kyleena® or Mirena® Quick Reference Guide

This guide provides easy to follow step by step information on the enrollment process and reimbursement process for the Copay Savings Program for Kyleena and Mirena.



The same steps below apply for enrolling in the Copay for Mirena program

Enrollment Process:

- HCP/Patients enroll by visiting iudcopay.com
- HCP/Patient can also enroll by visiting CopayforKyleena.com or CopayforMirena.com
- Select the option below if you are:
 - Enrolling as a patient
or
 - Enrolling as a healthcare provider
on behalf of a patient

Images are for demonstration purposes only



STEP 1: Eligibility

- HCP/Patient complete eligibility questions and click submit to continue to the next page.
- If answers to questions determine patient is not eligible for the program, the next page will say:

"We're sorry. Unfortunately you do not meet the program eligibility criteria and are ineligible to receive commercial co-pay assistance for Kyleena or Mirena. If you have any questions, please contact 1-833-244-2719."

Co-pay Savings Program for Kyleena®

Kyleena®
(levonorgestrel-releasing
intrauterine system) 19.5 mg

Eligibility for Patients

STEP 1 / STEP 2 / STEP 3

Required Field*

Are you a United States Resident?*

☐ Yes
☐ No

Do you currently have commercial health insurance for a portion of your prescription drug cost?*

☐ Yes
☐ No

Are you enrolled in any federal or state subsidized healthcare program that covers a portion of your prescription drug costs, including Medicare (such as Medicare Part D prescription drug benefit), Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs?*

☐ Yes
☐ No

*By activating the Co-pay card, you agree to the following statements:

- The information entered above is true and correct.
- You are not enrolled in a federal- or state-funded prescription drug benefit program, such as Medicare or Medicaid, or any private indemnity or HMO insurance plan that reimburses you for the entire cost of your prescription drug.
- You agree that you are not Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees.
- Should you begin receiving prescription benefits from one of these types of programs at any time, you will no longer participate in this savings program.

☐ I agree to the information above and I accept the Program Terms, Conditions, and Eligibility Criteria.

[Submit](#)

STEP 2: Patient Information

- If the HCP/Patient are eligible they will be taken to the next page where the patient's information is entered.
- Patient information includes:
 - Name
 - Phone Number
 - Date of birth
 - Email
 - Address
 - Patient Consent

Images are for demonstration purposes only

The screenshot shows the 'Patient Information' step of the enrollment process. It includes a progress bar with three steps: ELIGIBILITY, PATIENT INFORMATION (current), and PATIENT INSURANCE. Below the progress bar, there are input fields for 'First Name*', 'Last Name*', 'Caregiver', 'Date of Birth*' (with a MM/DD/YYYY format), 'Gender*' (Male/Female checkboxes), and 'Address*'. To the right, there is a preview of the 'Co-pay Savings Program for Kyleena' card, which displays the program name, Kyleena logo, and a small image of the IUD.

Congratulations!

- Once the HCP/Patient has clicked "Enroll" the next page will display a Congratulations message providing the patient's Co-pay Savings Program for Kyleena's (or Mirena's) information with instructions on how to use it.
- The HCP/Patient can choose to print this page.
- A welcome email will be sent to the patient with the same information.

The screenshot shows the 'Congratulations!' page. It features a 'Welcome to the Co-pay Savings Program for Kyleena!' message, followed by instructions to keep the co-pay card information and a list of details to provide to the healthcare provider: Rx BIN number, PCN number, Group number, and Co-pay Program ID. A 'Print' button is located below the instructions. To the right, there is a preview of the 'Co-pay Savings Program for Kyleena' card, which displays the program name, Kyleena logo, and a small image of the IUD. At the bottom, a note states: 'Your Co-pay Savings Program for Kyleena information has also been emailed to the address provided.'

HCP Co-pay Claim Reimbursement Process:

- Practice submits a claim for reimbursement to patient's insurance company using the CMS 1500 Form.
 - The CMS 1500 Form is commonly used by practices and is available to download on CoplayforKyleena.com or CoplayforMirena.com under "Forms"
- Practice submits the following documents to ConnectiveRx (CRx) via fax or mail:
 - Completed** and **signed** CMS 1500 form
 - Patient's explanation of benefits (EOB) or patient's explanation of payment (EOP)
 - Please write the patient's Co-pay Savings Program for Kyleena or Mirena ID on either the CMS 1500 Form or EOB
- Please note:** The practice has 180 day from the date of EOB to submit to CRx for reimbursement.
- Once CRx receives the paperwork, they will begin to process the claim.
- If claim is approved:**
 - A claim approval fax will be sent to the practice
 - A reimbursement check will be mailed to the practice within 5-7 business days of the claim being approved
- If claim is denied:**
 - A claim pending/rejection fax will be sent to the practice indicating what action is needed to correctly process the claim
 - Practice resubmits claim and review process starts over
- Once the claim is approved, a reimbursement check will be mailed to the practice within 5-7 business days.

The image displays three key documents in the reimbursement process:

- Health Insurance Claim Form (CMS 1500):** A standard form used for submitting claims to insurance companies. It includes sections for patient information, insurance details, and provider information.
- BlueCross BlueShield of North Carolina Explanation of Benefits (EOB):** A document explaining the insurance company's payment for a claim. It includes a table showing charges, allowed amounts, and patient responsibility. For example, it shows a charge of \$1,400.00 for a procedure, with an allowed amount of \$1,400.00 and a patient responsibility of \$0.00.
- Fax Transmission Form:** A form used to submit the claim to the Co-pay Savings Program. It includes fields for patient name, ID number, and a checkbox for "Co-pay Savings Program for Kyleena/Mirena".

EOB example is for demonstration purposes only

The image displays three key documents in the reimbursement process:

- Kyleena/Mirena Co-pay Savings Program Fax Transmission Form:** A form used to submit the claim to the Co-pay Savings Program. It includes fields for patient name, ID number, and a checkbox for "Co-pay Savings Program for Kyleena/Mirena".
- Kyleena/Mirena Co-pay Savings Program Fax Transmission Form:** A form used to submit the claim to the Co-pay Savings Program. It includes fields for patient name, ID number, and a checkbox for "Co-pay Savings Program for Kyleena/Mirena".
- Kyleena/Mirena Co-pay Savings Program Fax Transmission Form:** A form used to submit the claim to the Co-pay Savings Program. It includes fields for patient name, ID number, and a checkbox for "Co-pay Savings Program for Kyleena/Mirena".

Images are for demonstration purposes only

Patient Co-pay Claim Reimbursement Process:

- Patient contacts CRx to obtain a Bayer Co-pay Expenditure Form by calling 1-888-412-2247
- Patient submits the **completed** and **signed** Bayer Co-pay Expenditure Form along with their EOB and/or EOP to CRx via fax or mail
 - Patient will need to write the date of service on the form
- **Please note:** The patient has 180 day from the date of EOB to submit to CRx for reimbursement.
- Once CRx receives the paperwork, they will begin to process the claim.
- **If claim is approved:**
 - A claim approval letter will be sent to the patient
 - A reimbursement check will be mailed to the patient within 5-7 business days of the claim being approved
- **If claim is denied:**
 - A claim pending/rejection letter will be sent to the patient indicating what action is needed to correctly process the claim
 - Patient resubmits claim and review process starts over
- Once the claim is approved, a reimbursement check will be mailed to the patient within 5-7 business days.

Bayer \$0 Co-pay Assistance Programs

Co-pay Expenditure Form Instructions

Please follow the instructions below for completing and submitting a Co-pay Expenditure Form for a Bayer \$0 Co-pay Assistance Program. This form will be required for a patient to be reimbursed for their out-of-pocket expense if co-payment is paid by the patient.

- For each co-pay/insurance reimbursement request, please provide the following information:
 - Date of Service
 - Amount of co-pay/insurance reimbursement being requested for your Bayer product
 - When the check should be made payable
 - Important Note:** The reimbursement check can only be made payable to the patient or person who paid the co-pay amount.
 - Address to which the check should be mailed
 - Proof of payment from pharmacy where co-payment was made
- The Co-pay Expenditure Form **MUST** be signed and dated. **AND** all required documentation is:
 - Bayer \$0 Co-pay Assistance Programs
 - C/O Connecticut Claims Processing Center
 - P.O. Box 2355
 - Morristown, NJ 07962
- Proof of payment **MUST** be included with the Co-pay Expenditure Form. Receipts, explanation of benefits and/or claims that include (NDC) number, **MUST** be included in order to be reimbursed. Reimbursement cannot be issued without acceptable evidence.
- Payment will be sent within 7 to 14 business days after approval.
- Co-pay expenses incurred prior to your enrollment in the \$0 Co-pay program eligibility term has ended, may not be eligible.

If you have any questions regarding the Co-pay Expenditure Form or contact Bayer's \$0 Co-pay Assistance Program at 1-888-412-2247, 7 days a week.

IMPORTANT NOTICE: This program is not valid for prescriptions (except Medicaid, Medicare (including Medicare Part D), or other federal or state assistance programs). This program cannot be combined with all other programs. It is not transferable, is good only in the United States and is subject to certain eligibility requirements. Bayer reserves the right to modify, suspend, or terminate this program at any time. By using this program, you understand and agree to these terms. This program is not insurance.

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Bayer \$0 Co-pay Assistance Programs

Please make additional copies of this form for future use.

Section 1 – Bayer Co-pay Assistance Reimbursement Form

ALL fields are required. Complete this form in its entirety and include supporting documentation to avoid delays in reimbursement.

The following 6 fields can be found on the pharmacy receipt:

Product Name: _____ Received/Date of Service (MM/DD/YYYY): _____
 NDC: _____ Ref: _____
 Quantity: _____ Day Supply: _____
 Patient First Name: _____ Patient Last Name: _____
 Patient Date of Birth: _____
 Co-pay Card Group Number: _____ Co-pay Card Member ID: _____
 Primary Payer/Insurance Name: _____ Primary Payer ID: _____
 Amount of Reimbursement Requested (Documentation Required): _____
 Make Check Payable to: _____
 (Check can only be made payable to the patient or person who paid co-pay amount)
 Address: _____
 City: _____ State: _____ Zip: _____

Section 2 – Declaration

I verify that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Bayer's \$0 Co-pay Assistance Program. I understand that assistance will terminate if the Program reasonably suspects any fraudulent activity relating to the assistance provided by the Program. I understand that assistance may be limited to the terms and conditions established by the Program and that the Program reserves the right at any time or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all of the program and the related eligibility criteria, or (iii) terminate assistance.

I authorize Bayer, the \$0 Co-pay Assistance Program, their employees and agents, third party administrators, and other representatives to obtain information from my healthcare providers and insurance coverage information from my employer, insurance company(ies), or specialty pharmacy(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Signature (required): _____ Date: _____

Please mail or fax this completed form along with required documentation to:

Bayer \$0 Co-pay Assistance Programs OR FAX: (844) 622-5475
 C/O Connecticut Claims Processing Center
 P.O. Box 2355, Morristown, NJ 07962

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Re: Co-pay Savings Program for Kyleena® Claim Approval

Dear <Patient First Name> <Patient Last Name>:

The Co-pay Savings Program for Kyleena® claim submission received payment in the amount of <\$55.55>.

Your provider's office staff will credit your account for the amount of <\$55.55> covering your out-of-pocket cost.

Please feel free to contact us at 1-833-244-2719 if you have any questions.

Sincerely,

The Co-pay Savings Program for Kyleena®

Re: Co-pay Savings Program for Kyleena® Claim Approval

Dear <Patient First Name> <Patient Last Name>:

Thank you for your participation in the Co-pay Savings Program. The amount of <\$55.55> covering your out-of-pocket cost has been credited to your account.

If you have any questions, please feel free to call 1-833-244-2719.

Sincerely,

The Co-pay Savings Program for Kyleena®

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MAC-KYL-US-0065-1 03/2020

PSKW, LLC
2 Corporate Drive
Suite 200
Morristown, NJ 07962

PAY To: And No/100 Dollars/Dollars

TO: BAYER, INC.

DATE: 03/20/20

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MAC-KYL-US-0065-1 03/2020

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Re: Co-pay Savings Program for Kyleena® Claim Approval

Dear <Patient First Name> <Patient Last Name>:

Thank you for participating in the Co-pay Savings Program for Kyleena®. We have received and reviewed your submission on behalf of <Patient First Name> <Patient Last Name> and unfortunately are unable to approve the claim for the following reasons:

- Incorrect documentation: A copy of the Explanation of Benefits (EOB) is required
- Missing Co-pay Savings Program for Kyleena® ID number
- Missing primary insurance plan information or photograph of front and back of primary insurance card
- Missing signature
- Claim outside of program parameters – please do not resubmit
- Claim not valid (incorrect drug, strength, NDC) – please do not resubmit
- Duplicate claim – please do not resubmit
- Patient is covered under a government plan and is not eligible for the program. Please do not resubmit
- Other: (Open text field for miscellaneous product/issue)

We apologize for any inconvenience. We will be happy to reprocess your request if your claim is valid and all required information and materials are resubmitted. Please resubmit to the following address:

Connecticut
 Attn: Co-pay Savings Program for Kyleena®
 PO Box 2236
 Morristown, NJ 07962
 Fax: 1-833-244-2720

To expedite processing, please include this letter with any future correspondence.

If you have already been contacted by our office and have sent in additional information as requested, please disregard this letter. Please feel free to contact us at 1-833-244-2719 if you have any questions.

Sincerely,

The Co-pay Savings Program for Kyleena®

You may request not to receive Kyleena from Bayer HealthCare Pharmaceuticals, Inc. (BHC) Business Unit. To stop receiving such boxes, please do not return the following and/or Co-pay Savings Program for Kyleena® ID number to BHC (1-833-244-2719) or resubmit to the appropriate address. You may also request that the specific telephone number of the fax machine at which you wish to receive boxes from us. We will remove your box number from our list and will not send you additional boxes. Failure to comply with your request within 30 days of receipt of this letter will result in boxes being sent to you. You may have a right to request that we remove your name from our list. You must provide express consent to receive such boxes at the fax number/telephone number or email address listed below.

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