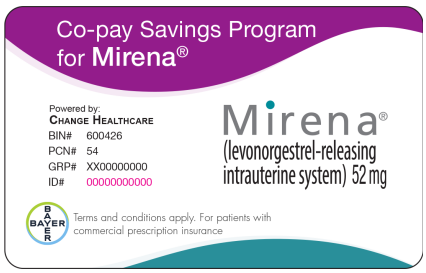
Kyleena®
(levonorgestrel-releasing intrauterine system) 19.5 mg

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:

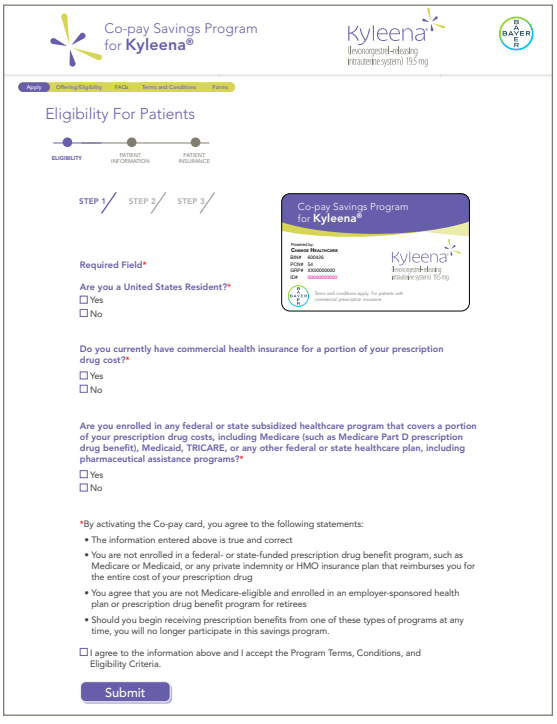
- HCP/Patients enroll by visiting **iudcopay.com**
- HCP/Patient can also enroll by visiting CopayforKyleena.com or CopayforMirena.com
- Select the option below if you are:
  - Enrolling as a patient
    or
  - Enrolling as a healthcare provider on behalf of a patient

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."



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
  - Date of birth
  - Address
  - Phone Number
  - Email
  - Patient Consent

Images are for demonstration purposes only

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.

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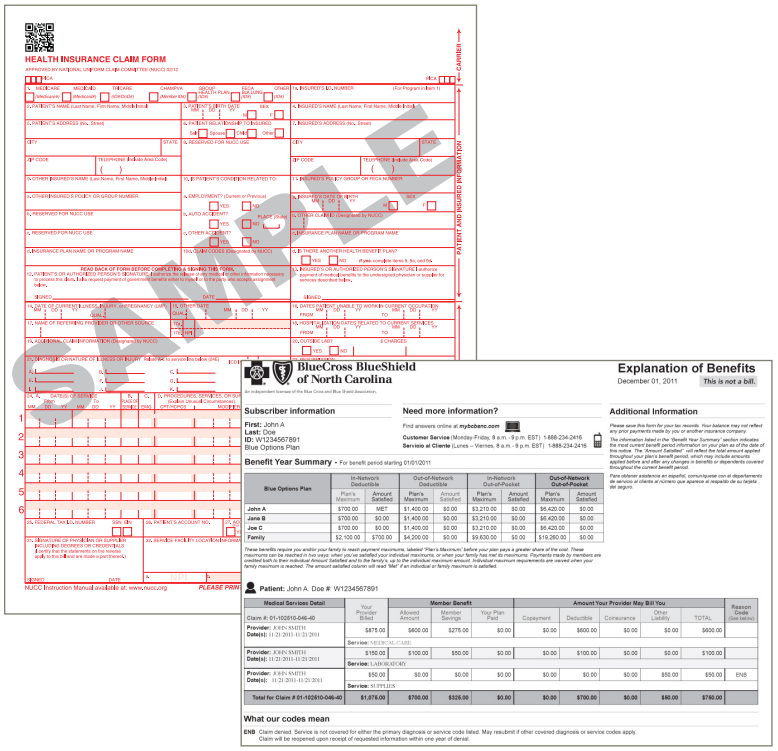
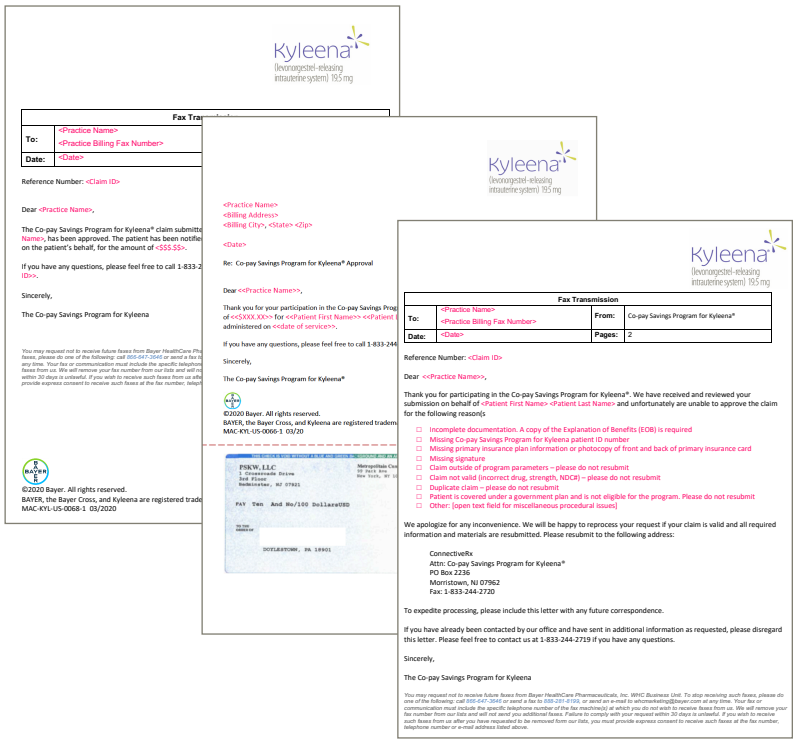
HCP Co-pay Claim Reimbursement Process:

- 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 CopayforKyleena.com or CopayforMirena.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.



EOB example is for demonstration purposes only

- 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.



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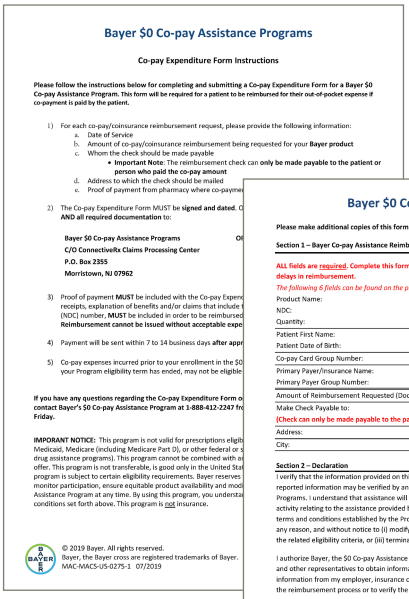
Patient Co-pay Claim Reimbursement Process:

- 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.

1) For each co-pay/coinsurance reimbursement request, please provide the following information:
   a. Date of Service
   b. Amount of co-pay/coinsurance reimbursement being requested for your **Bayer product**
   c. Whom 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**
   d. Address to which the check should be mailed
   e. Proof of payment from pharmacy where co-payme

2) The Co-pay Expenditure Form MUST be **signed and dated.** C
AND all required documentation to:

Bayer $0 Co-pay Assistance Programs
C/O ConnectiveRx Claims Processing Center
P.O. Box 2355
Morristown, NJ 07962

3) Proof of payment **MUST** be included with the Co-pay Expens
receipts, explanation of benefits and/or claims that include t
(NDC) number, **MUST** be included in order to be reimburse
Reimbursement cannot be issued without acceptable expe

4) Payment will be sent within 7 to 14 business days **after appr**

5) Co-pay expenses incurred prior to your enrollment in the $0
your Program eligibility term has ended, may not be eligible

If you have any questions regarding the Co-pay Expenditure Form o
contact Bayer's $0 Co-pay Assistance Program at 1-888-412-2247 fr
Friday.

IMPORANT NOTICE: This program is not valid for prescriptions eligib
Medicaid, Medicare (including Medicare Part D), or other federal or s
drug assistance programs). This program cannot be combined with a
offer. This program is not transferable, is good only in the United Stat
program is subject to certain eligibility requirements. Bayer reserves
monitor participation, ensure equitable product availability and mod
Assistance Program at any time. By using this program, you understa
conditions set forth above. This program is not insurance.

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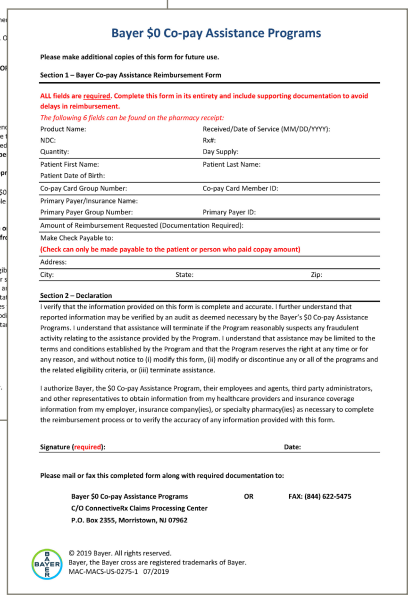
Bayer $0 Co-pay Assistance Programs

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: Rx#:
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 Group Number: 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 copay 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 Programs. 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 programs 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 ConnectiveRx Claims Processing Center
P.O. Box 2355, Morristown, NJ 07962

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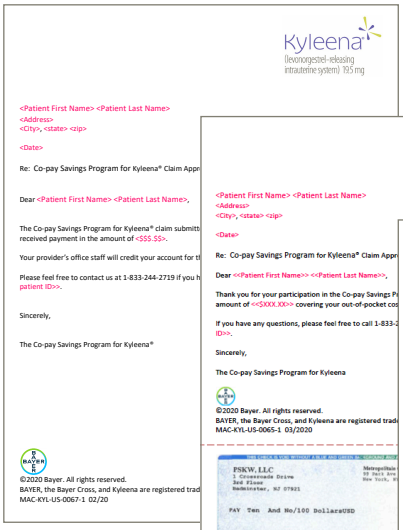
Kyleena®
(levonorgestrel-releasing intrauterine system) 19.5 mg

<Patient First Name> <Patient Last Name>
<Address>
<City>, <state> <zip>

<Date>

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

Dear <Patient First Name> <Patient Last Name>,

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

Your provider's office staff will credit your account for t

Please feel free to contact us at 1-833-244-2719 if you h
patient ID>>.

Sincerely,

The Co-pay Savings Program for Kyleena®

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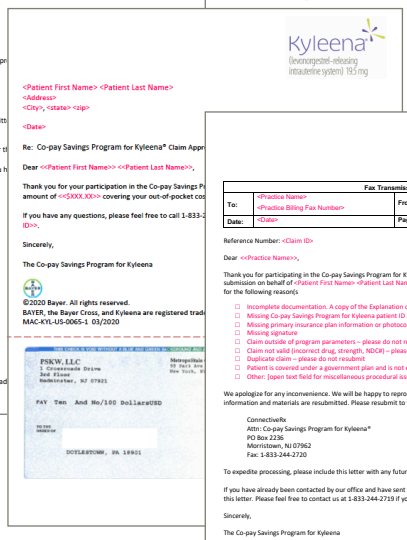
Kyleena®
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<Patient First Name> <Patient Last Name>
<Address>
<City>, <state> <zip>

<Date>

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

Dear <<Patient First Name>> <<Patient Last Name>>,

Thank you for your participation in the Co-pay Savings P
amount of <<$XXX.XX>> covering your out-of-pocket cos

If you have any questions, please feel free to call 1-833-
ID>>.

Sincerely,

The Co-pay Savings Program for Kyleena

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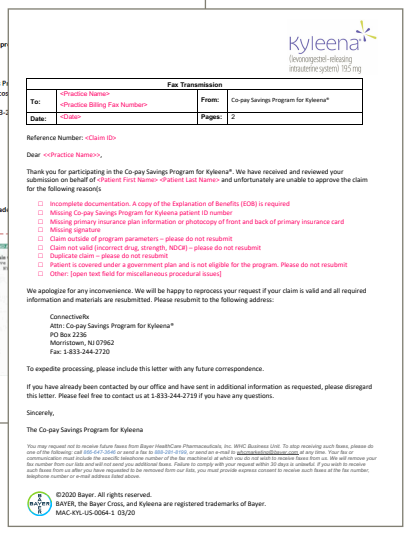
PSKW, LLC
1 Crosswoods Drive
2nd Floor
Bedminster, NJ 07921

PAY Ten And No/100 DollarsUSD

DOYLESTOWN, PA 18901


Kyleena®
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Fax Transmission

To:	<Practice Name> <Practice Billing Fax Number>	From:	Co-pay Savings Program for Kyleena®
Date:	<Date>	Pages:	2

Reference Number: <Claim ID>

Dear <<Practice 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 reason(s):

- ☐ Incomplete documentation. A copy of the Explanation of Benefits (EOB) is required
- ☐ Missing Co-pay Savings Program for Kyleena patient ID number
- ☐ Missing primary insurance plan information or photocopy 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 procedural issues]

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:

ConnectiveRx
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 future faxes from Bayer HealthCare Pharmaceuticals, Inc. WHC Business Unit. To stop receiving such faxes, please do one of the following: call 888-647-3646 or send a fax to 888-297-9788, or send an e-mail to structuredsupport@bayer.com, at any time. Your fax or communication must include the specific telephone number of the fax machine/s at which you do not wish to receive faxes from us. We will remove your fax number from our lists and will not send you additional faxes. Failure to comply with your request within 30 days is unlawful. If you wish to receive such faxes from us after you have requested to be removed from our lists, you must provide express consent to receive such faxes at the fax number, telephone number or e-mail address listed above.

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