

Kyleena[®]
(levonorgestrel-releasing
intrauterine system) 19.5 mg

Mirena[®]
(levonorgestrel-releasing
intrauterine system) 52 mg

Skyla[®]
(levonorgestrel-releasing
intrauterine system) 13.5 mg

**Reimbursement Rebate Program for
Kyleena[®], Mirena[®], Skyla[®] Effective 1/1/2021**

<p>Program Description and Eligibility:</p>	<p>Customers with Kyleena[®], Mirena[®] and Skyla[®] inventory purchased 1/1/2021 through 9/30/2021, which is subsequently reimbursed by a commercial payer at less than the customers' net acquisition cost, are eligible to participate in the program.</p> <p>For each Kyleena, Mirena or Skyla unit that is under-reimbursed for patient dates of service from 1/1/2021 through 9/30/2021, customers may receive a rebate up to the difference between the customer's net acquisition cost for the unit and the documented payer reimbursement allowable. The "net acquisition cost" is the cost for the unit including any Volume and/or Contracted Discounts. Reimbursement allowable is the total provider reimbursement for that unit, including any patient cost share. Customers will not be required to sign a contract to participate in the program.</p> <p>Please note that the maximum possible rebate amount is \$250 per unit.</p> <p>This program does not apply to any reimbursement received from state or federal healthcare programs, such as Medicaid, Managed Medicaid, Tricare, or Medicare.</p>
<p>Rebate Request Form Submission Instructions:</p>	<ul style="list-style-type: none"> ✓ Provide information for each Kyleena, Mirena or Skyla unit for which you are requesting a rebate on the attached Reimbursement Rebate Request Form. You may submit requests for multiple units on the same form, and attach additional pages as needed. ✓ Submit the Reimbursement Rebate Request Form for Kyleena, Mirena or Skyla (refer to next page) to Bayer with copies of: <ul style="list-style-type: none"> ○ (1) the Bayer Direct or AmerisourceBergen Specialty Distributor (ASD) invoice. ○ (2) the de-identified paid claim/Explanation of Benefits (EOB) for each unit that was under-reimbursed. ○ (3) your current W-9 form ✓ The latest date to submit a reimbursement rebate request to Bayer is 12/31/2021 ✓ <u>Note: Patient Health Information (PHI) MUST be redacted or the submission will be denied.</u> ✓ Be sure to sign the rebate request form before submitting. <p>Two ways to submit the attached form and supporting documentation:</p> <ol style="list-style-type: none"> 1. E-mail to: <u>WHCREBATES@BAYER.COM</u>. 2. Fax to 862-404-2111 <p>Please allow up to 6 weeks for processing after a complete rebate request form has been submitted. If information is missing from the submitted request form, a Bayer representative will contact you to obtain the missing information. Rebate checks will be made payable to the entity listed as the "bill to" addressee on the Bayer Direct or ASD invoice.</p>
<p>Reporting Requirements:</p>	<p>Customers who receive rebates under this program must comply with all federal and state healthcare program reporting and disclosure rules for discounts and rebates.</p>
<p>Questions:</p>	<p>If you have questions about how to fill out the request form, or you want to check the status of a submitted request, please contact Bayer at 855-966-4584, option 2, for assistance.</p>

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 866-647-3646, or send an e-mail to kenneth.rehm@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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Reimbursement Rebate Request Form for Kyleena[®], Mirena[®] and Skyla[®] - Effective January 01, 2021

Provider Name:	Office Contact Name and Title:
Office Contact Phone Number:	Office Contact E-mail address:
By signing below I certify that the information provided on this form and any attachments is accurate. I also certify that I am not requesting a rebate for units provided to patients covered by a government health benefit program.	
Signature: _____ Date: _____	
Total number of pages submitted with this request, including this one: _____	
<p>You may e-mail or fax the completed form and documents. Email: WHCREBATES@BAYER.COM. reimbursement rebate request. Fax: 862-404-2111</p> <ul style="list-style-type: none"> ✓ Be sure to include a copy of your Bayer Direct and/or ASD invoice. ✓ For explanation of benefits (EOBs), please remove/blackout all Patient Health Information (PHI) to maintain HIPAA compliance. ✓ Please include a copy of your most recent W-9 	

Patient ID number	Patient Date of Service	Total Reimbursement Allowable Including Any Patient Cost-Share for: J7296 (Kyleena)*, J7298 (Mirena), J7301 (Skyla),	Net Acquisition Cost (from Invoice)	Payer Name	Paid Claim/EOB (insert check mark)
					Attached__
					Attached__
					Attached__
					Attached__

***Note: Some payers may continue the use of Q9984 or S4989 to describe coding and billing for Kyleena**

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					Attached___
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