XIAFLEX®
collagenase clostridium histolyticum

Copay Assistance Program Proof of Expense

If you are eligible to participate in the Endo Advantage™ Copay Assistance Program, but your pharmacy or provider does not participate in the Program, you may use this Proof of Expense Form to request reimbursement for XIAFLEX® (collagenase clostridium histolyticum). The Program will reimburse you for XIAFLEX® only, and does not cover any other products or other out-of-pocket costs (for example, office visit charges, office visit copays, or injection/administration costs), even if those costs are associated with the administration of a dose of XIAFLEX®. This offer is not valid for prescriptions reimbursed in whole or in part by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, or similar federal or state programs.

PRACTICE BILLING INFORMATION (all fields are required)

Practice Name (check will be made payable to) _____ Practice NPI _____ Practice Tax ID _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____

Contact Phone Number _____ Email Address _____

Physician First Name _____ Physician Last Name _____ Physician NPI _____

PATIENT INFORMATION—MUST BE SIGNED BY PATIENT (all fields are required)

First Name _____ Middle _____ Last Name _____ Gender _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____ Date of Birth _____

Phone _____ Email _____ Date Product Received (MM/DD/YYYY) _____

XIAFLEX® Copay Assistance Program Group # EC55003018 XIAFLEX® Copay Assistance Program ID # 38607926518

PATIENT CERTIFICATION AND CONSENT—MUST BE SIGNED BY PATIENT

"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 Endo Advantage™ Copay Assistance Program (the "Program"). I understand that assistance will end if the Program becomes aware of 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 the Program and the related eligibility criteria, or (iii) terminate assistance. I authorize the Program and its employees, third-party administrators, agents and other representatives to obtain treatment and insurance-related information from my healthcare providers and insurance coverage information from my employer or insurance company(ies), as necessary, to complete the reimbursement process or to verify the accuracy of any information provided with this form."

Patient Signature: _____

Please remit assistance to (select 1):

☐ Patient

☐ Practice/Physician (If Practice option is selected, payment will be made in accordance with the Practice Information provided above.)
Assignment of Benefits

I hereby assign all financial assistance available to me through the XIAFLEX® Copay Assistance Program to be payable to Practice listed above. Practice will receive all financial assistance, on my behalf, through the XIAFLEX® Copay Assistance Program and will credit my account accordingly.

Patient Signature: _____ Date _____

REIMBURSEMENT PROCESS

Payment cannot be issued without proof of expense. Please provide at least one of the following documents with this completed form:*

- Explanation of benefits
- Payment receipts
- Billing statement

The Program will disburse your payment, if approved, within 7 to 14 business days of the receipt of a completed request. If you have any questions about the Proof of Expense Form or the payment process, please call the Endo Advantage™ Copay Assistance Program at 1-866-585-5591.

*Please submit this documentation within 90 days from the date of service (the date the prescription was filled). The Program will contact you by phone to obtain any missing information and will accept claims for up to 120 days after your eligibility expires. You will be reimbursed only for expenses incurred while you were enrolled in the Program.

PLEASE FAX THIS COMPLETED FORM TO: 1-908-809-6249

For additional questions about your XIAFLEX® treatment, please call 877-XIAFLEX (877-942-3539).

For questions about the XIAFLEX® Copay Assistance Program, the program offer, or this form, please call 1-866-585-5591.

Please click here for full Prescribing Information, including Boxed Warning and Medication Guide.

endo ADVANTAGE™ Committed to Access

XIAFLEX®
collagenase clostridium histolyticum

Copay Assistance Program Proof of Expense Form (cont)

How the XIAFLEX® Copay Assistance Program May Help Cover Out-of-Pocket Costs

If you are billing your patient's insurance plan for XIAFLEX® (collagenase clostridium histolyticum), or if your patient is paying cash for the XIAFLEX® injections, your patient may be eligible to participate in the XIAFLEX® Copay Assistance Program. Eligible patients can receive up to $1200 toward their out-of-pocket cost for each vial of XIAFLEX®. Please see XIAFLEX.com for additional patient eligibility requirements.

The XIAFLEX® Copay Savings Program Process

- Determine your patient's insurance status and coverage for XIAFLEX®
- Administer XIAFLEX®
- If your patient is insured, submit a claim for XIAFLEX® to your patient's insurance plan
- You and your patient will receive an Explanation of Benefits (EOB), indicating the exact amount that was reimbursed and the exact amount your patient owes for XIAFLEX®
- For eligible patients, submit the XIAFLEX® claim form to the program via fax, email, or mail. Claims should be accompanied by a copy of the EOB for insured patients or a copy of the receipt for cash patients
- The program will provide reimbursement up to the maximum amount allowed

PLEASE FAX THIS COMPLETED FORM TO: 1-908-809-6249

For questions about the XIAFLEX® Copay Assistance Program, the program offer, or this form, please call 1-866-585-5591.

Please click here for full Prescribing Information, including Boxed Warning and Medication Guide.

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Rx Only

MM-05439/September 2019 www.xiaflex.com 1-800-462-ENDO (3636)