

impoyz™



(clobetasol propionate)  
Cream, 0.025%

**MOST COMMERCIALY INSURED, DRUG  
COVERED PATIENTS PAY NO MORE THAN\***

**\$25 CO-PAY**

**BIN** 600426

**PCN** 54

**GRP** EC12801010

**ID** 39184277169

**\* Eligibility Requirements**

- Patients enrolled in a state or federally funded prescription insurance program are not eligible for this offer. This includes patients enrolled in Medicaid, Medicare Part D, Medigap, Department of Defense (DOD), Tricare, Veterans Affairs (VA) programs or Medicare eligible patients enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees or where prohibited by law.
- Patients with private commercial insurance, and Impoyz™ Cream is covered, pay no more than \$25. Patients with private commercial insurance, and Impoyz Cream is not covered, pay no more than \$50. Cash-paying, or uninsured patients, pay no more than \$75.
- Offer valid for up to 12 prescription fills.

**Patient Instructions:** Eligible patients must present this savings card at participating pharmacies with a valid prescription, including Prescriber ID # for eligible Encore Dermatology products. By using this offer, you are certifying that you meet the eligibility criteria and will comply with the terms and conditions described below. Please call **1-844-829-1152** with questions.

**Pharmacist:** When you apply this offer, you are certifying that the patient meets the eligibility criteria, that you have not submitted and will not submit a claim for reimbursement under any state- or federally-funded prescription insurance program for this prescription, and that participation in program is not contrary to your agreements with third-party payors or applicable laws or regulations for pharmacy providers.

**Pharmacist instructions for a patient with an Eligible Third Party:** Submit the claim to the primary Third Party Payer first, then submit the balance due to **CHANGE HEALTHCARE** as a Secondary Payer COB [coordination of benefits] with patient responsibility amount and a valid Other Coverage Code, **(e.g. 8)**. The insured patient when drug is covered by their plan is responsible for \$25, and the insured patient when drug is not covered by their plan is responsible for \$50. Reimbursement will be received from **CHANGE HEALTHCARE**.

**Pharmacist Instructions for a Cash-Paying Patient:** Submit this claim to **CHANGE HEALTHCARE**. A valid Other Coverage Code **(e.g. 1)** is required. The patient is responsible for \$75 and remaining reimbursement will be received from **CHANGE HEALTHCARE**.

Valid Other Coverage Code required. For any questions regarding **CHANGE HEALTHCARE** online processing, please call the Help Desk at **1-800-433-4893**.

**Restrictions:** This offer is valid in the United States. It is illegal to (or offer to) sell, purchase, or trade this offer. Void where prohibited by law, taxed or restricted. This offer is not conditioned on any past, present or future purchase, including refills. **Program expires 6/30/2019**. Program managed by ConnectiveRx on behalf of Encore Dermatology. Encore Dermatology reserves the right to rescind, revoke, or amend this program at any time. Not valid if reproduced. Not redeemable for cash. This is not a health insurance card.

This card is valid for Impoyz Cream only.

For more information, please refer to [www.encorederm.com](http://www.encorederm.com).

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