

REBATE PROGRAM

Receive up to a \$50 rebate when you purchase DORYX[®] Delayed-Release Tablets.

To receive your rebate, you will need to do the following:

1. Purchase your prescription for DORYX[®] Delayed-Release Tablets. **This rebate is valid for both new and refill prescriptions.**
2. Print a copy of this certificate for each prescription purchased.
3. Fill out all of the required information on this certificate completely.
4. Attach the **original** pharmacy prescription receipt with the product name and price listed. Photocopies and cash register receipts will not be accepted.
5. Mail this certificate along with the **original** pharmacy prescription receipt to:

DORYX[®] Rebate
c/o Triple i
PO Box 2063
Morrisville, PA 19067-0563

If you have any questions about this rebate, please call
1-800-588-9701, Monday-Friday 9:00 am – 5:00 pm EST.

Your rebate check will be mailed to you within 6 to 8 weeks.

Please fill out the below information completely.

Please check one box:

- I paid a \$_____ copay. Rebate is limited to \$50.00 or the amount of your copay, whichever is less.
- I am eligible for a \$50.00 rebate. My purchase price was:
\$_____.

(Please Print)

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone (Optional): _____

E-mail (Optional): _____

Date of Birth: _____ Gender (M/F): _____

Eligibility Criteria: **1.** This rebate is not valid for prescriptions purchased under Medicaid, Medicare, other federal or state programs (including any state prescription drug programs), or private indemnity or HMO insurance plans which reimburse you for the entire cost of your prescription drugs. **2.** Offer good only in the U.S. **3.** Warner Chilcott (US), LLC reserves the right to rescind, revoke or amend this offer without notice. **4.** You understand and agree to comply with the terms and conditions as set forth in this offer. **5.** There is a limit of 1 rebate for each prescription of 30 tablets or more filled. Offer void in **Massachusetts** except for patients with no prescription drug insurance coverage. Void if prohibited by law, taxed or restricted.

Important: Please sign before mailing. Your signature is required to confirm you have read the terms and that you are eligible to receive a rebate. Without your signature, we are not authorized to fulfill this rebate.

Please Sign Here: _____ Date: ____/____/____