SAVINGS PROGRAM FOR VITAFOL® FAMILY

#1 PRESCRIBED PRENATAL VITAMIN

VITAFOL ULTRA | VITAFOL Fe+ | VITAFOL gummies | VITAFOL Nano | VITAFOL One | VITAFOL STRIPS

Select-OB+DHA | Vitafol-OB+DHA

Eligible patients may
PAY AS LITTLE AS

$25 PER 1-MONTH OR 3-MONTH PRESCRIPTION FILL*

*See below for program details.

NO ACTIVATION NEEDED!

3-month fill
may cost patient
$8.33
per month

Powered by:
CHANGE HEALTHCARE

BIN# 004682
PCN# CN
GRP# ECVITAFOL
ID# VITAFOL

Eligible Patients may also access via **text**

Text **VITAFOL** to **26729**

TAKE THE **FIRST STEP** WITH VITAFOL®

MAIL ORDER PATIENTS:

If you fill your prescription through a mail-order pharmacy, or if you are unable to have your card processed at your local pharmacy, Please submit:

1. A photocopy of the front and back of your Savings Card.
2. Your original proof of purchase (original pharmacy receipt with your name and address, pharmacy name, product name, prescription numbers, NDC number, date filled, quantity, and price) and a photocopy of the front and back of your insurance card.
3. Your date of birth.
4. Mail all of the information to:

Vitafol® Savings Program
c/o ConnectiveRx
200 Jefferson Park, Whippany, NJ 07981

Please allow 6-8 weeks to receive your reimbursement. Reimbursements are subject to Program Terms, Conditions, and Eligibility Criteria.

Dear Pharmacist: The patient is responsible for the first $25 of their co-pay and cash-paying patients should pay approximately $65. Prescriber ID# required on prescription. **Not valid for individuals enrolled in Medicare, Medicaid, a state pharmaceutical assistance program, or any other federal or state health care program.**

Patient Instructions: In order to redeem this card you must have a valid prescription for Vitafol®-Ultra, Vitafol Fe+, Vitafol-One, Vitafol-OB+DHA, Select-OB+DHA, Select OB, or Vitafol Gummies. The patient is responsible for the first $25 of their co-pay and cash-paying patients should pay approximately $65. Follow the dosage instructions given by the doctor. This card may not be redeemed for cash. **You are not eligible for this offer if you are enrolled in Medicare, Medicaid, or any other federal or state healthcare program. If out-of-pocket cost on the 90-day fill is above $60, ask your pharmacist to process a 30-day fill instead.** Cardholders with questions, please call **1-855-881-3090**.

Pharmacist Instructions for a Patient with an Eligible Third Party Payer: 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 patient is responsible for the first $25 of their co-pay. 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 the first $25 of their co-pay and cash-paying patients should pay approximately $65. Reimbursement will be received from **CHANGE HEALTHCARE**.

Valid Other Coverage Code required. For any questions regarding this coupon, or **CHANGE HEALTHCARE** online processing, please call the Help Desk at **1-800-422-5604**.

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Rethinking healthcare

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