The codes below can be used for all your eligible customers*

Pay as little as $9
for 90 days.*

Expiration Date: 12/31/2021
No Activation Required.

**Limitations apply. See below for details.*
Reimbursement limited to $150 per month or $450 on a 90 day fill.

Powered by:
CHANGE HEALTHCARE

BIN# 004682
PCN# CN
GRP# ECVASCEPA
ID# 59021139303

Vascepa®
(icosapent ethyl)

Pharmacist and Beneficiary: When you use this card, you are certifying that you have not submitted and will not submit a claim for reimbursement under any Federal, State, or other Governmental programs for this prescription.

The patient is responsible for the first $9 of their co-pay and the card pays up to the next $150 of their remaining co-pay due per monthly fill or $450 on a 90 day fill prior to 12/31/2021. Prescriber ID# required on prescription. Not for use by residents of VT, nor Medical professionals licensed in VT. May not be used to obtain prescription drugs paid for by Federal or State Healthcare Programs including Medicare Part D. This offer is not valid for those patients under 18 years of age or patients whose plans do not permit use of a co-pay card.

Patient Instructions*:** In order to redeem this card you must have a valid prescription for VASCEPA® (icosapent ethyl) and otherwise meet all eligibility criteria. Follow the dosage instructions given by the doctor. This card may not be redeemed for cash. Cardholders with questions, please call ***1-855-497-8462.

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 $9 and the card pays up to the next $150 on a monthly fill or $450 on a 90 day fill. 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 $9 and the card pays up to the next $150 on a monthly fill or $450 on a 90 day fill. 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 1-800-422-5604.

Program expires 12/31/2021. Program managed by ConnectiveRx on behalf of Amarin Pharma, Inc. The parties reserve the right to rescind, revoke or amend this offer without notice at any time. Not valid if reproduced. Void where prohibited by law, taxed or restricted.

Do not process coupon if government beneficiary.

AMARIN®

Vascepa®
(icosapent ethyl)

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