VASCEPA® SAVINGS PROGRAM Manual Rebate Form

Send form to:
VASCEPA Savings Program
PO Box 2355
Morristown, NJ 07962

This form is to be used by Amarin Pharma Inc's vendor, ConnectiveRx, for ConnectiveRx to determine reimbursement of a patient's copayment or out-of-pocket expenses directly and actually incurred for a prescribed dose of **VASCEPA** under the **VASCEPA SAVINGS PROGRAM**.

Please complete this form online then print it. Before you complete this form, please know that you will be asked for certain confidential information. Receipt of this information is mandatory in order to receive payment.

By completing this form, you hereby waive any privacy rights regarding your individual or prescriber information, your diagnosis, and your prescription medical coverage data.

I agree to give this information (please check box): ☐

Amarin Pharma Inc.'s vendor, ConnectiveRx, will administer benefits under this program and will shred all documents 60 days after processing. Costs incurred for general office visits will not be reimbursed. Payment of the co-pay reimbursement is subject to verification.

PATIENT INFORMATION – please print

First Name ☐ Middle ☐ Last Name ☐

Address 1 ☐ Address 2 ☐

City ☐ State ☐ Zip ☐

Phone ☐ Email ☐

DOB ☐ Gender ☐ Age ☐

PRESCRIBER INFORMATION – please print

First Name ☐ Middle ☐ Last Name ☐

Address 1 ☐ Address 2 ☐

City ☐ State ☐ Zip ☐

Phone ☐

Your completed reimbursement form must also have the items below. Forms submitted without these items will not be valid and therefore will not be eligible to receive reimbursement. Forms will take 6 to 8 weeks to process.

- ✓ Copy of VASCEPA prescription label (includes name and address of pharmacy, dosing, and days supply)
- ✓ Copy of the front of VASCEPA Savings Card
- ✓ Dated original receipt (proof of purchase or invoice) with the amount of copayment or out-of-pocket expenses highlighted
- ✓ Patient signature—see below

I hereby certify that:

- ✓ I am over the age of 18 years old
- ✓ I paid cash for my Vascepa prescription
- ✓ My prescription was not paid in full or in part by a state or federally funded program like Medicare Part D, VA, Medicare, Medicaid, or TriCare.
- ✓ I am not a resident of Vermont or of any state or place that prohibits the use of, taxes or restricts copay cards.
- ✓ The information provided for this reimbursement request is accurate to the best of my knowledge, and the copayment or out-of-pocket expenses requested for reimbursement were actually incurred.

I certify that the information provided for this reimbursement request is accurate to the best of my knowledge.

Patient Signature _____

For additional questions, please call **1-855-497-8462**.