Symbicort®
(budesonide/formoterol fumarate dihydrate) Inhalation Aerosol

PAY AS LITTLE AS $35*

NO ACTIVATION REQUIRED

*Terms and conditions apply. Government restrictions exclude people enrolled in federal government insurance programs from co-pay support.

ELIGIBLE COMMERCIALLY INSURED PATIENTS

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(budesonide/formoterol fumarate dihydrate) Inhalation Aerosol

*Subject to eligibility rules. Restrictions apply.

No Activation Required.

BIN# 610020
PCN# PDMI
GRP# 99995264
ID# AZPS200024

Must have a valid SYMBICORT prescription.

ELIGIBILITY: You may be eligible for this offer if you are insured by commercial insurance and your insurance does not cover the full cost of your prescription. Patients who are enrolled in a state- or federally funded prescription insurance program are not eligible for this offer. This includes patients enrolled in Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs, or TriCare, and patients who are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. If you are enrolled in a state- or federally funded prescription insurance program, you may not use this savings card even if you elect to be processed as an uninsured (cash-paying) patient. This offer is not insurance and is restricted to residents of the United States or a United States Territory (Puerto Rico, Guam, U.S. Virgin Islands, Northern Mariana Islands, American Samoa).

TERMS OF USE: Eligible commercially insured/covered patients with no restrictions (step-edit, prior authorization, or NDC block) and a valid prescription for SYMBICORT® (budesonide and formoterol fumarate dihydrate) Inhalation Aerosol who present this savings card at participating pharmacies will pay as low as $35 for each 30-day supply (1 inhaler), subject to a maximum savings limit; patient out-of-pocket expenses may vary. Other restrictions may apply. Patient is responsible for applicable taxes, if any. Non-transferable, limited to one per person, cannot be combined with any other offer. Void where prohibited by law, taxed, or restricted. Card savings are not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. Other state restrictions may apply. Patients, pharmacists, and prescribers cannot seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this offer. AstraZeneca reserves the right to rescind, revoke, or amend this offer, eligibility, and terms of use at any time without notice. This offer is not conditioned on any past, present, or future purchase, including refills. Offer must be presented along with a valid prescription at the time of purchase. If you have any questions regarding this offer, please call 1-800-687-3755.

ADDITIONAL PROGRAM TERMS AND CONDITIONS: At its sole discretion and with or without notice, AstraZeneca may reduce, eliminate, or otherwise modify the card for any reason, including but not limited to if your commercial drug insurance plan imposes additional requirements which limit or prevent you from receiving coverage for your inhaler, only allow partial coverage for your inhaler, remove coverage for your inhaler and require you to utilize the card, do not provide a material level of financial assistance for the cost of your inhaler, or do not apply program payments to satisfy your co-payment, deductible, or coinsurance for your inhaler. You must meet the eligibility criteria, terms and conditions every time you use the card.

BY USING THIS CARD, YOU AND YOUR PHARMACIST UNDERSTAND AND AGREE TO COMPLY WITH THESE ELIGIBILITY REQUIREMENTS AND TERMS OF USE.

Pharmacist Instructions for a Patient With an Eligible Third-Party Payer:

For Insured/Covered Patients: Submit the claim to the primary Third-Party Payer first, then submit the balance due to **Pharmacy Data Management Inc** as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 8. This will reduce the eligible patient's out-of-pocket costs to as low as $35 for each 30-day supply (1 inhaler), subject to a maximum savings limit for the program; patient out-of-pocket expenses may vary. Reimbursement will be received from **Pharmacy Data Management Inc**.

For any questions regarding **Pharmacy Data Management Inc** online processing, please call the Help Desk at 1- 800-800-7364.

You may *report side effects related to AstraZeneca products.*

AstraZeneca

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