XIAFLEX®
collagenase clostridium histolyticum

XIAFLEX® Copay Assistance Program Proof of Expense Form

By accepting this offer, you agree to report the value received under this offer to any health insurer or other third party paying for any part of your XIAFLEX® prescription if you are required to do so by benefit terms, contract, or law. This offer is not valid for prescriptions reimbursed in whole or in part by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, similar federal or state programs, or where otherwise prohibited by law. By accepting this offer, you agree that Endo Pharmaceuticals Inc. or those working on its behalf may contact your doctor to verify information about treatment that is relevant to verifying your eligibility for this offer. This offer is only valid for doses of XIAFLEX® administered in the US. The XIAFLEX® Copay Assistance Program can be used only by eligible residents of the US, or US territories at participating eligible pharmacies in the US, or US territories. This offer is valid for the out-of-pocket cost for the dose of XIAFLEX® only. Offer is not valid for any other products or other out-of-pocket costs (for example, office visit charges, office visit copays, or injection/administration costs) even if those costs are associated with the administration of a dose of XIAFLEX®. The selling, purchasing, trading, or counterfeiting of this offer is prohibited. Endo Pharmaceuticals Inc. reserves the right to rescind, revoke, or amend this offer without notice. By participating, you understand and agree to comply with the terms and conditions of this offer as set forth above. Please see XIAFLEX.com for additional patient eligibility requirements.

PRACTICE BILLING INFORMATION (all fields are required)

Practice Name (check will be made payable to) _____ Practice NPI _____ Practice Tax ID _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____

Contact Phone Number _____ Email Address _____

Physician First Name _____ Physician Last Name _____ Physician NPI _____

PATIENT INFORMATION—MUST BE SIGNED BY PATIENT (all fields are required)

First Name _____ Middle _____ Last Name _____ Gender _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____ Date of Birth _____

Phone _____ Email _____

XIAFLEX® Copay Assistance Program Group # EC55003024 XIAFLEX® Copay Assistance Program ID # 38607926518

PATIENT CERTIFICATION AND CONSENT—MUST BE SIGNED BY PATIENT

"I certify that 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 also certify that the XIAFLEX® I received was not reimbursed in whole or in part by Medicare, Medicare Prescription Drug Benefit plans, Medicare Advantage, VA, Medicaid, or similar federal or state programs."

Patient Signature: _____

Please remit assistance to (select 1):

○ Patient

◉ Practice/Physician (If Practice option is selected, payment will be made in accordance with the Practice Information provided above.)

Assignment of Benefits

I hereby assign all financial assistance available to me through the XIAFLEX® Copay Assistance Program to be payable to Practice listed above. Practice will receive all financial assistance, on my behalf, through the XIAFLEX® Copay Assistance Program and will credit my account accordingly.

Patient Signature: _____ Date _____

REIMBURSEMENT PROCESS

Complete this form in its entirety and submit it with the following items:

- For insured patients: Attach a copy of the Explanation of Benefits (EOB) highlighting the out-of-pocket expenses for XIAFLEX®.
- For cash-paying patients: Attach the receipt indicating the amount paid by the patient for XIAFLEX®.

Submit reimbursement claim and attachments via mail or fax:

Mail: XIAFLEX® Copay Assistance Program
PO Box 2355
Morristown, NJ 07962

Fax: 1-908-809-6249

Note: Forms sent via fax will take up to 10 business days to process. Forms sent by mail may take up to 15 business days to process.

For additional questions about your XIAFLEX® treatment, please call 877-XIAFLEX (877-942-3539).
For questions about the XIAFLEX® Copay Assistance Program, the Program offer, or this form, please call 1-866-585-5591.

XIAFLEX®
collagenase clostridium histolyticum

XIAFLEX® Copay Assistance Program
Proof of Expense Form (cont)

How the XIAFLEX® Copay Assistance Program May Help Cover Out-of-Pocket Costs

If you are billing your patient's insurance plan for XIAFLEX® (collagenase clostridium histolyticum), or if your patient is paying cash for the XIAFLEX® injections, your patient may be eligible to participate in the XIAFLEX® Copay Assistance Program. Please see XIAFLEX.com for additional patient eligibility requirements.

The XIAFLEX® Copay Assistance Program Process

1. Determine your patient's insurance status and coverage for XIAFLEX®
2. Administer XIAFLEX®
3. If your patient is insured, submit a claim for XIAFLEX® to your patient's insurance plan
4. You and your patient will receive an Explanation of Benefits (EOB), indicating the exact amount that was reimbursed and the exact amount your patient owes for XIAFLEX®
5. For eligible patients, submit the XIAFLEX® claim form to the Program via fax or mail. Claims should be accompanied by a copy of the EOB for insured patients or a copy of the receipt for cash patients
6. The Program will provide reimbursement up to the maximum amount allowed

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