

Copay Rebate Form

REBATE PROGRAM INSTRUCTIONS:

If your pharmacy does not accept or cannot process your PAXLOVID™ (nirmatrelvir tablets; ritonavir tablets) Co-Pay Savings Card, use this rebate form to request reimbursement of your out-of-pocket co-pay costs for PAXLOVID.*

1. **Complete** the rebate form below.
2. **Circle** the medication name, the date, and the amount you paid for PAXLOVID on your original pharmacy receipt. (Cash register receipt is *not* valid.)
3. **Ensure** your pharmacy receipt includes the following information:
 - Patient name and address
 - Pharmacy name, address, and phone number
 - Doctor or healthcare provider name, address, and phone number
 - Prescription # (Rx #), fill date, drug name, strength, NDC #, and quantity
 - Overall prescription price and co-pay/out-of-pocket expense paid
4. **Send** in the completed rebate form along with your pharmacy receipt:



By Mail: Attn: Claims Processing Department, IQVIA, Inc.
430 Mountain Avenue, Suite 105, New Providence, NJ 07974

OR



By Fax: 1-908-382-9209 (toll free)

COMPLETE AND RETURN THIS FORM:

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE

EMAIL

DATE OF BIRTH

CO-PAY SAVINGS CARD MEMBER ID #

DAYS SUPPLY

CLAIMANT MUST SIGN HERE

SIGNATURE

DATE

By my signature, I certify that I meet and agree to the terms and conditions listed on this rebate form, as well as the eligibility requirements and restrictions that I receive when I activate my card.

To validate, you must sign and date this rebate form. The rebate check will arrive in 6-8 weeks. An additional rebate form is provided in the event it is necessary to submit another request for reimbursement.



QUESTIONS?

Please call 1-833-276-5308
Monday–Friday, 8:00 AM–8:00 PM ET

*Limits, terms and conditions apply, listed on this page.

PAXCESS™
Patient Support Program



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PAXCESS™ CO-PAY SAVINGS CARD REBATE TERMS & CONDITIONS

By sending this rebate, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:

Eligible commercially insured patients prescribed PAXLOVID must be 12 years of age or older to redeem the rebate. The patient's primary diagnosis must be for an FDA-approved or FDA-authorized indication. Patients are not eligible to participate in this program if they are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). This rebate is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit programs. Rebate is not valid for cash-paying patients. The value of the prescription offer is limited to the amount of your copay. Patients may receive up to a maximum benefit of \$1500 per calendar year, which is defined by the date of enrollment through December 31st of the enrollment year. Patient must submit a completed rebate request form and the original, dated store identified receipt accompanying your prescription as proof of purchase to the address provided on this form. Receipt will not be returned. See instructions on rebate request form. Rebate will be mailed to patients approximately 6 to 8 weeks after receipt of required documentation or earlier, as required by law. You must deduct the value received under this rebate from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf. Patient is responsible for reporting receipt of rebate to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription for which the patient receives a rebate, as may be required. You should not use this program if your private insurer or health plan prohibits use of manufacturer savings programs. This rebate is not valid where prohibited by law. The benefit under the rebate is offered to, and intended for the sole benefit of, eligible patients and may not be transferred to or utilized for the benefit of third parties, including, without limitation, third party payers, pharmacy benefit managers, or the agents of either. This rebate cannot be combined with any other external savings, free trial or similar offer for the specified prescription (including any program offered by a third party payer or pharmacy benefit manager, or an agent of either, that adjusts patient cost-sharing obligations, through arrangements that may be referred to as "accumulator" or "maximizer" programs). Third party payers, pharmacy benefit managers, or the agents of either, are prohibited from assisting patients with enrolling in the rebate program. **This rebate is not health insurance.** Offer good only in the U.S. and Puerto Rico. No other purchase is necessary. Data related to your redemption of the rebate may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs. Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other rebate redemptions and will not identify you. Pfizer reserves the right to rescind, revoke, or amend the program without notice. Rebate and Program expires 12/31/2025.

For questions or additional support, call 1-833-276-5308 or visit the PAXLOVID website at www.paxlovid.com.