

## FREE TRIAL OFFER\* FOR ELIGIBLE PATIENTS

- Eligible patients of the **Free Trial Offer** will receive one **30-day supply FREE\***

\*Subject to eligibility rules; restrictions apply

For Medicare Part D, Medicaid  
or Cash-Paying Patients

**RECEIVE A 30-DAY  
SUPPLY OF FARXIGA®**  
(dapagliflozin) tablets

Powered by:

CHANGE HEALTHCARE  
BIN# 004682  
PCN# CN  
GRP# EV57010067  
ID# 414959805230

  
**farxiga®**  
(dapagliflozin) 5mg  
tablets

Limit one voucher per  
patient for the duration of  
the program.

For reimbursement,  
please submit to CHANGE  
HEALTHCARE.

Program managed by  
ConnectiveRX on behalf of  
AstraZeneca.

### For Eligible Patients of the Free Trial Offer:

Offer good for eligible patients purchasing up to a 30-day supply of FARXIGA tablets with a valid prescription for FARXIGA. Offer may be changed or discontinued at any time without notice. Offer not valid for mail order or for patients under 18 years of age. Offer not valid where prohibited by law, taxed, or restricted. Offer is not transferable, is not insurance, is limited to one per person, and may not be combined with any other offer. More details on FARXIGA.com. Please call 1-844-631-3978 with questions and for full eligibility details.

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

### Medicaid, Medicare or Cash Paying Patients:

This offer may be used by eligible patients who participate in Medicaid, Medicare, or similar federal or state programs, or for patients who are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees or if you pay cash for your prescriptions. You will receive one 30-day prescription free.

### Pharmacist Instructions for Medicare Part D, Medicaid and Cash-Paying Patients:

For reimbursement, please submit electronically to CHANGE HEALTHCARE. The information printed on the front should be used when submitting for reimbursement. No claim for payment can be made to ANY Third-Party Payer for product dispensed pursuant to this offer. Not valid if reproduced. For questions, please call the Help Desk at 1-800-422-5604.


You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.FDA.gov/medwatch](http://www.FDA.gov/medwatch) or call 1-800-FDA-1088.

If you are without prescription coverage and cannot afford your medication, AstraZeneca may be able to help.

If you would like additional information regarding AstraZeneca products, please contact the Information Center at AstraZeneca in the US at 1-800-236-9933, Monday through Friday, 8 am to 8 pm ET, excluding holidays, or visit [AstraZeneca-us.com](http://AstraZeneca-us.com).

Program managed by ConnectiveRx on behalf of AstraZeneca.

Product dispersed pursuant to program rules and federal and state laws.

 This product information is intended for US consumers only.

  
AstraZeneca

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For Eligible Commercially  
Insured Patients

**RECEIVE A 30-DAY  
SUPPLY OF FARXIGA®**  
(dapagliflozin) tablets

Powered by:

CHANGE HEALTHCARE  
BIN# 004682  
PCN# CN  
GRP# EC57010066  
ID# 414959805226

  
**farxiga®**  
(dapagliflozin) 5mg  
tablets

Limit one voucher per  
patient for the duration of  
the program.

For reimbursement,  
please submit to CHANGE  
HEALTHCARE.

Program managed by  
ConnectiveRX on behalf of  
AstraZeneca.

**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, is restricted to residents of the United States and Puerto Rico, and to patients over 18 years of age.

**Terms of Use:** Eligible commercially insured patients with a valid prescription for FARXIGA® (dapagliflozin) tablets who present this savings card at participating pharmacies will pay \$0 for one 30-day supply. Other restrictions may apply. Patient is responsible for applicable taxes, if any. Nontransferable, limited to one per person, cannot be combined with any other offer. Void where prohibited by law, taxed or restricted. 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 1-844-631-3978.

**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:

**For Insured/Covered Patients:** Submit the claim to the primary Third-Party Payer first, then submit the balance due to CHANGE HEALTHCARE as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 8. The patient is responsible for \$0. Reimbursement will be received from CHANGE HEALTHCARE.

**For Insured/Not Covered Patients:** Submit the claim to the primary Third-Party Payer first, if the primary claim submission shows a managed care restriction (step-edit, prior authorization or NDC block), continue the claim adjudication process and submit the balance due to CHANGE HEALTHCARE as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 3. The patient is responsible for \$0. 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.