

# INSTANT SAVINGS<sup>†</sup>

No Activation Required

**CO-PAYS AS LITTLE AS \$0\***

For commercially insured patients

Please see accompanying Full Prescribing Information and Medication Guide for KOMBIGLYZE XR (5/500•5/1000•2.5/1000 mg tablets), including **Boxed WARNING** about lactic acidosis.

Subject to eligibility. Restrictions apply. Not available for government-insured patients. See back of card for details.

**onglyza kombiglyze XR**  
(saxagliptin) 5 mg tablets (saxagliptin and metformin HCl extended-release) tablets

Emdeon  
Therapy First Plus

BIN# **004682**  
PCN# **CN**  
GRP# **EC57027020**  
ID# **414350328010**

onglyzasavings.com kombiglyzesavings.com

\*As low as \$0 for as long as your doctor prescribes any available dose of either ONGLYZA or KOMBIGLYZE XR. No activation required.

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\*Subject to eligibility. Restrictions apply. Not available for government-insured patients.

**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, or you are not insured and are responsible for the cost of your prescriptions. 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 ONGLYZA® (saxagliptin) or KOMBIGLYZE® XR (saxagliptin and metformin HCl extended-release) who present this savings card at participating pharmacies will pay \$0 per 30-day supply subject to a maximum savings of \$150 per 30-day supply. If you pay cash for your prescription, AstraZeneca will pay up to the first \$150, and you will be responsible for any remaining balance, for each monthly prescription. 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. 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 1-855-907-3197.

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 **Therapy First Plus** 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 \$0 per 30-day supply subject to a maximum savings of \$150. Reimbursement will be received from **Therapy First Plus**.

**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 **Therapy First Plus** as a Secondary Payer COB with patient responsibility amount and a valid Other Coverage Code of 3. This will reduce eligible patient's out-of-pocket costs to \$0 per 30-day supply subject to a maximum savings of \$150. Reimbursement will be received from **Therapy First Plus**.

**Pharmacist Instructions for a Cash-Paying Patient:** Submit this claim to **Therapy First Plus**. A valid Other Coverage Code (eg, 1) is required. The card will cover up to \$150 per 30-day supply. Reimbursement will be received from **Therapy First Plus**.

**Valid Other Coverage Code Required.** For any questions regarding **Therapy First Plus** online processing, please call the Help Desk at 1-800-422-5604.

Please click on product name to see Full Prescribing Information including **Boxed WARNING** and Medication Guide, for **KOMBIGLYZE XR**.

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 EST, excluding holidays, or visit [AstraZeneca-us.com](http://AstraZeneca-us.com).

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