

Boehringer Ingelheim Pharmaceuticals, Inc.
Savings Card Terms and Conditions for
Synjardy® (empagliflozin/metformin HCl) tablets and
Synjardy® XR (empagliflozin/metformin HCl extended-release) tablets

To the patient: Patients who meet the eligibility criteria may pay as little as \$10/month with a maximum savings up to \$175 per 30-day supply. Benefits not to exceed program expiration on December 31, 2024. In Massachusetts and California, the validity of this voucher and its use are subject to state law. Other state restrictions may apply. One card per patient, not transferable, and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer. **Card not accepted in Veterans Affairs pharmacies.** Program not health insurance. You must present this card to the pharmacist with your SYNJARDY or SYNJARDY XR prescription to participate. Only valid for commercially insured patients in the 50 United States, DC, and Puerto Rico whose insurance policy provides coverage for SYNJARDY or SYNJARDY XR who are not reimbursed for the entire cost of the prescription. **Offer not valid for patients without commercial coverage or patients whose prescriptions for SYNJARDY or SYNJARDY XR are eligible to be reimbursed, in whole or in part, by any governmental program such as Medicaid, Medicare, Medigap, the Retiree Drug Subsidy Program, VA, DOD, TRICARE®, or any state patient or pharmaceutical assistance program and where prohibited by law.** Offer not valid for prescriptions for SYNJARDY or SYNJARDY XR that are eligible to be reimbursed, in whole or in part, by any state employee health plans where prohibited by law. Offer may change at any time, without notice. Offer is intended to comply with all applicable laws and regulations, including, without limitation, the federal Anti-Kickback Statute, its implementing regulations, and related guidance interpreting the federal Anti-Kickback Statute. The selling, purchasing, trading, or counterfeiting of the offer is prohibited by law. The offer has no cash value.

Insurance plans, PBMs and other third-party companies are prohibited from enrolling or assisting in the enrollment of patients in the PROGRAM. The patient, or his/her legal representative, must personally enroll in the Program in order to be eligible for program benefits.

The value of the Program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles.

By enrolling in the Program, you agree that this program is intended solely for the benefit of you, the patient.

Some insurance plans have established programs referred to as ‘accumulator adjustment’ or ‘co-pay maximizer’ programs which requires you to enroll in a manufacturer copay assistance program. An accumulator adjustment program is one in which payments made by you that are subsidized by manufacturer assistance do not count toward your deductibles and other out-of-pocket cost sharing limitations. Co-pay maximizers are programs in which the amount of your out-of-pocket costs is increased to reflect the availability of support offered by a manufacturer assistance program. Except where prohibited by applicable state law, if your insurance company, health plan or other company implements either an accumulator adjustment or co-pay maximizer program, you will not be eligible for, and agree not to use, the Program because these programs are inconsistent with our agreed intent that this program is solely for your benefit. Since you may be unaware whether you are subject to a co-pay maximizer program when you enroll in the co-pay assistance program, if Boehringer Ingelheim suspects or is made aware that you are subject to one of these programs, we reserve the right to discontinue copay assistance at any time.

To the pharmacist: Use of this card certifies that you have not and will not submit a claim for reimbursement for this prescription under any federal, state or other governmental programs.

- Submit transaction to McKesson Corporation using BIN #610524.
- If primary coverage exists, input card information as secondary coverage and transmit using the COB segment of the NCPDP transaction. Applicable discounts will be displayed in the transaction response.
- Acceptance of this card and your submission of claims for the JARDIANCE Savings Card Program are subject to the LoyaltyScript® program Terms and Conditions posted at www.mckesson.com/mprstnc
- Patient is not eligible if patient's prescription for JARDIANCE is eligible to be reimbursed, in whole or in part, by any governmental program such as Medicaid, Medicare, or any state patient or pharmaceutical assistance program.
- Not valid for patients receiving Medicare Part A covered care in a facility (including, but not limited to, a hospital, skilled nursing facility, nursing home, and hospice).
- The LoyaltyScript® Card is not valid for use with any other prescription drug discount or cash cards for JARDIANCE. Claims submitted utilizing the program are subject to audit or validation. For questions regarding setup, claim transmission, patient eligibility or other issues, call the LoyaltyScript® for JARDIANCE Savings Card Program at 1-866-279-8990 8:00 AM-8:00 PM EST, Monday-Friday, Saturday 9:30 AM - 6:00 PM EST.

Please see [Prescribing Information](#), including Boxed Warning, and [Medication Guide](#) for SYNJARDY and SYNJARDY XR.

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