Imvexxy®
(estradiol vaginal inserts)
4 mcg • 10 mcg

MEDICARE PART D ALTERNATIVE COUPON PROGRAM OPT OUT LETTER TO HEALTH PLAN

To whom it may concern:

I am an enrollee in your prescription drug plan, and this Opt Out Letter is to advise you that I have been prescribed Imvexxy® _____ mcg by my physician. I am purchasing Imvexxy® outside of my insurance benefit with the Imvexxy® Medicare Part D Alternative Coupon Program card sponsored by Mayne Pharma.

This Opt Out Letter is not a request for reimbursement, as I have agreed to not seek reimbursement for my purchase of Imvexxy® in accordance with the Terms and Conditions of the Imvexxy® Medicare Part D Alternative Coupon Program card. If I am an enrollee in Medicare Part D or a Medicare Advantage prescription drug plan, I also have agreed that I will not count my purchases toward my true out-of-pocket expenses (TrOOP), and I will continue to use the Imvexxy® Medicare Part D Alternative Coupon Program card for as long as I take the medication during the calendar year.

If you have questions about the medication or the Imvexxy® Medicare Part D Alternative Coupon Program card, please contact Mayne Pharma at 1-800-344-8661, Monday to Friday from 8 am to 5 pm EST.

Sincerely

Name _____ Date _____

Prescription Plan _____ Date of Birth _____

Prescription Plan Membership ID Number _____

mayne pharma

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