Co-Pay Program*

CHECK REQUEST FORM

1 PATIENT INFORMATION

Patient First Name | Patient Last Name

AVSOLA™ Co-Pay Program Member ID (Found on member's card)

Patient Mailing Address | Apartment/Unit/Suite

City | State | ZIP

2 PHYSICIAN AND PRACTICE INFORMATION

Physician First Name | Physician Last Name

Practice Name and Location

Practice Mailing Address | Apartment/Unit/Suite

City | State | ZIP

3 CHECK INFORMATION

Check Recipient (Please check one) ☐ Patient ☐ Practice

The check will be mailed to the address provided for the marked recipient. Please make sure to provide the corresponding address in this form.

Date(s) of Service (mm/dd/yyyy)

Amount Requested | Signature

In addition to the documentation required by the program, when selecting "Patient" as a check recipient, make sure to include ***proof of payment*** *as part of the document submission.*

Preferred Fax-Back Number for Notification (Optional)

Entering a fax number here indicates you would like to receive fax confirmation that the check has been sent to the address provided.

Please send the completed form along with Explanation of Benefits (and Proof of Payment, if required) to:

- **FAX:** 1-866-406-6155

OR

- **MAIL TO:** ConnectiveRx
  100 Passaic Avenue, Suite 245
  Fairfield, NJ 07004
  Attention: AVSOLA™ Co-Pay Program

*Terms, conditions, and program maximums apply. Other restrictions may apply. See AVSOLAsupport.com for details. This program is not open to patients receiving prescription reimbursement under any federal, state, or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DoD) or TRICARE® or where otherwise prohibited by law. The facsimile transmission and accompanying documents contain information that is confidential or privileged. This information is intended for the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of contents of this faxed information is strictly prohibited. If you received this fax in error, please notify us by telephone (1-866-264-2778) so that we can arrange for the return of the original documents to us and the retransmission of them to the intended recipient. Patients must meet all eligibility requirements to qualify. For program details, please visit www.AVSOLAsupport.com or call 1-866-264-2778.

Please see full Prescribing Information.

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