



# Mail-in Rebate Request

If you purchased your medication and were not able to utilize your co-pay card at the pharmacy, please complete and submit this form along with your health plan's Explanation of Benefits (EOB), itemized bill or pharmacy receipt (this is not the cash register receipt) that shows the purchase of ZENPEP® (pancrelipase) via fax 855-915-3041 or mail to:

**Z-Save Patient Savings Program**  
2250 Perimeter Park Drive, Suite 300  
Morrisville, NC 27650

See full terms and conditions of the program on the next page. If you have any questions about your participation with the Z-Save Savings Program, please call 1-833-742-0707 for further assistance.

Offer valid for commercially insured patients only. Do not submit for any claim that was paid for by Medicare, Medicaid, Champus, TriCare, VA or any other federal or state healthcare program, Flexible Spending Account (FSA), Health Savings Account (HSA), Health Reimbursement Account (HRA), or any other payor or discount/copy program. Unapproved claims will not be paid.

## PATIENT INFORMATION

Patient Full Name: \_\_\_\_\_  
Last\* First\* M.I.

Member ID\*: \_\_\_\_\_ Date of Birth\*: \_\_\_\_/\_\_\_\_/\_\_\_\_  
See the 11-digit number that appears on the front of your copay card

Address: \_\_\_\_\_  
Street\* Apartment/Unit Number

City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ ZIP Code\*: \_\_\_\_\_

Parent/Legal Guardian's Email: \_\_\_\_\_

Parent/Legal Guardian's Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## CERTIFICATION STATEMENT

"I am already enrolled in the Z-Save Patient Support Program ("Program") and have activated my card on <https://www.zenpep.com/savings-programs>, I read, understand, and agree to the Terms and Conditions of the Program listed on this form and on <https://www.zenpep.com/savings-programs>, including the Eligibility requirements and limitations, and I grant permission to Nestlé Health Science, its affiliates, or service providers to use my information for the purposes related to the administration of the Program and to share it with my healthcare provider(s) and insurance plan(s)."

Patient Name\*: \_\_\_\_\_

Patient/Guardian Signature \*\*: \_\_\_\_\_

Parent/Guardian Name\*: \_\_\_\_\_

Date\*: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*This form will not be processed without a valid signature of the patient (if at least 18 years of age) or the patient's parent or legal guardian.

The information you provide on this form will only be used by Nestlé Health Science, its affiliates, or service providers for the purposes of administering the Z-Save Savings Program. To remove yourself from these communications and leave the Program, please call 1-833-742-0707. Please see Nestlé Health Science's [Privacy Policy](#) to learn more about how we protect your information.

**Please see full Prescribing Information and Medication Guide, available at [ZENPEP.com](https://www.zenpep.com)**

\* Required



## Program Terms, Conditions, and Eligibility Criteria:

1. This offer is good for use only with a valid prescription for **ZENPEP® (pancrelipase) delayed-release capsules** at the time the prescription is filled by the pharmacist and dispensed to the patient.
2. Depending on your insurance coverage, most eligible patients may pay as little as \$0 for the first ZENPEP prescription and \$30 for each refill of ZENPEP. Check with your pharmacist for your copay discount. Maximum savings limit applies; patient out-of-pocket expense may vary.
3. This offer is not valid for use by patients enrolled in, nor shall the copay prescription be submitted for reimbursement to, Medicare (including Medicare Advantage), Medicaid (including managed Medicaid plans), Medigap, TRICARE, or other federal or state programs (including any state pharmaceutical assistance programs), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. This offer is not valid for cash-paying patients.
4. This offer is valid for up to twelve (12) prescription fills of a 30-day supply or up to four (4) prescription fills of a 90-day supply. Offer applies only to prescriptions filled before the program expires on April 30, 2023.
5. Nestlé reserves the right to rescind, revoke, or amend this offer without notice.
6. Offer good only in the USA, including Puerto Rico, at participating retail pharmacies.
7. For California and Massachusetts residents, benefits pursuant to this card will terminate automatically upon the introduction of a therapeutically equivalent product.
8. Void if prohibited by law, taxed, or restricted.
9. This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law.
10. This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription.
11. This offer is not health insurance.
12. This card expires April 30, 2023.
13. Certain information related to your use of the card may be collected, analyzed, and shared with Nestlé for market research and other purposes related to assess Nestlé's programs. Information shared with Nestlé will be aggregated and deidentified; it will be combined with other data related to other card redemptions and will not identify you. **By redeeming this card, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.**

**For questions about the program, including savings on mail-order prescriptions, please call 1-833-742-0707.**