Patient Rebate Form

Livalo® (pitavastatin) tablets
1 mg, 2 mg, 4 mg

Please complete this form entirely and submit with all required information and attachments to be considered for reimbursement. Refer to program card for complete terms and conditions.

Section 1 – Patient Information (please print)

Patient Name: _____ Patient Gender: ☐ Male ☐ Female

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____ Savings Card ID: _____

Section 2 – Insurance Information - Required

Do you have prescription insurance? ☐ No ☐ Yes

If Yes, my prescription benefit provider is: _____

My insurance covered: ☐ This entire prescription ☐ None of this prescription ☐ All except copay of $ _____

This prescription was filled at ☐ A retail pharmacy store ☐ Through mail order or specialty pharmacy

Quantity dispensed: _____ Days supply: _____

Section 3 – Pharmacy Receipt/Invoice - Required

Mail this completed form along with the following items to:

Patient Rebate, 680 Century Point, Ste 1000, Lake Mary, FL 32746

Failure to include any of the following will result in a delay in processing or denial of your claim.

The original pharmacy receipt or invoice received must include the following information:

- Patient name and address
- Pharmacy name, address and phone number (can be found on your receipt or invoice, if not please provide)
- Prescription # (RX#), medication fill date, drug name, strength, NDC #, quantity dispensed, and days supply
- Prescription price and/or copay amount that you paid
- The cash register receipt or invoice with the amount paid for this prescription clearly identified

Certification Statement - Required

"I, _____ , certify that the information provided in this request is accurate, that expenses requested for payment were actually incurred. Void where prohibited by law. Kowa Pharmaceuticals reserves the right to rescind, revoke or amend this program without notice. Offer not valid for patients eligible for benefits under Medicaid (including Medicaid managed care), Medicare, TRICARE, Veterans Affairs, or similar state or federal programs. Offer void where prohibited, taxed, or otherwise restricted. Offer good only in the U.S.A. No generic substitution with this offer. Kowa reserves the right to rescind, revoke, or amend the offer at any time.

Claimant/Patient/Legal Guardian Signature: _____ Date: _____

Please allow 2 weeks for processing. Your reimbursement will be sent to your email provided on the rebate form.
Please call the LIVALO Patient Support Line at 1-844-567-9504.

Kowa