

# Patient Rebate Form



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, 2325 Heritage Center Drive, Ste 317, Furlong, PA 18925

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.

