Patient Co-Pay Reimbursement Form

For qualified patients only. Restrictions apply. Patients insured through federal, state, or other government programs, including Medicare and Medicaid, are not eligible for this program. See program rules and eligibility requirements at http://envarsusxr.pskw.com.

Within four weeks of filling a valid prescription, please take the following steps to receive reimbursement:

1. Complete this form
2. Mail this form and the original pharmacy receipt to:

Envarsus XR Patient Savings Program
PO Box 7017
Bedminster, NJ 07921

The original pharmacy receipt should include:

1. Patient Name and Address
2. Pharmacy Name, Address and Phone Number
3. Prescription #, Fill Date, Drug Name, Strength, NDC #, and Quantity
4. Amount of your out-of-pocket payment

First Name

Last Name

Date of Birth (MM/DD/YYYY)
MM/DD/YYYY

Street Address

City

State

Zip

Phone #

Group # (*on your Envarsus XR card*)

ID # (*on your Envarsus XR card*)

Do you have commercial insurance?
Yes No

Name of the insurer

BIN #

PCN #

Drug Name

Drug Strength