Enrollment Form

Door to Door
Your Brand On Demand

Mobic® (meloxicam) tablets Program Enrollment Form

IMPORTANT: Please complete all 4 sections in their entirety

❑ I will mail my prescription

- Write your date of birth on the original copy of your prescription
- Mail completed Enrollment Form with your original MOBIC prescription to:
  Door to Door c/o Eagle Pharmacy
  PO Box 90937
  Lakeland, FL 33804
- Allow 5-9 days for delivery following receipt of Enrollment Form

❑ My doctor will submit my prescription

- See instructions on back
- Entire form must still be completed by patient

You can also enroll by calling 1-855-799-6834 or visiting MobicDoorToDoor.com

1. Patient Information

Name _____
First Middle initial Last

Date of birth (mm/dd/yyyy) _____/_____/_____ Gender ❑ Male ❑ Female

Shipping address_____

City_____ State_____ ZIP_____

Primary phone number (_____)_____ Email_____

Additional Information

Do you have any drug allergies?
❑ No ❑ Yes If yes, please list

_____

_____

Are you taking other medications?
❑ No ❑ Yes If yes, please list (include over-the-counter, herbal, vitamins, etc.)

_____

_____

Please list any health conditions:

_____

2. Prescription Refill Selection (You must choose a refill amount.)

Your first 30-day supply is FREE with your enrollment.*

❑ One-month supply for $30* ❑ Three-month supply for $75 — less than $1 a day*

3. Payment Information (This section must be completed for your order to be processed.)

Credit Card: By providing your credit card information you authorize your credit card to be charged no more than $30 or $75* depending on the refill amount you select.

Name on credit card _____ Credit card number _____

Expiration _____ CVC (3-digit code on back, or 4 on front) _____

Signature _____

Would you prefer to be enrolled in an automatic refill plan? Please check: ❑ Yes ❑ No

If so, you are acknowledging that every month we will ship the medication to the address on file and charge the appropriate amount to the credit card provided.

***See Terms and Conditions on the next page.**

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***Terms and Conditions:** Patients must have a valid prescription for Mobic® (meloxicam) tablets.

By enrolling, I elect to receive the branded product and acknowledge that no generic substitution will be offered (if applicable). Should I wish to receive a generic product in the future, I will call 1-855-799-6834 to opt out of this program.

Patients have a choice of two payment structures: 1) Patients can enroll for a one-month supply at $30 for 30 tablets of MOBIC, or 2) Patients can enroll for a three-month supply at $75 for 90 tablets of MOBIC. All patients, upon initial enrollment, will receive an additional free one-month supply (30 tablets) of MOBIC. Enrollment includes the fee payment for the initial prescription.

If you have Medicare Part D, Medicaid, or a similar state or federally funded medical assistance program, you will pay a cash price of $30 for a one-month supply, or $75 for a three-month supply of MOBIC. All Medicare Part D orders are processed without the use of insurance and cannot be applied to Part D true out-of-pocket (TrOOP) costs. State and local taxes may apply.

Boehringer Ingelheim Pharmaceuticals, Inc. retains the right to rescind, revoke, or amend this offer at any time without notice.

4. Please Check the Box Below

❑ I agree to the Privacy Statement Policy below and allow Boehringer Ingelheim to use my information to provide me with health-related information, useful materials, and offers regarding their products.

This information is being collected by Boehringer Ingelheim Pharmaceuticals, Inc. so that we may advertise our products to you and provide you with information about them. We will not share your private information with anyone else—including mailing lists.

We respect your right to have personal medical information kept confidential. Companies working with us will use the information you provide to send you information, seek your opinions, and help develop products, services, and programs. If we provide you with coupons or vouchers for our products, the information we receive from the pharmacy regarding their use will also be used for the same purposes.

❑ My doctor will submit my prescription

(**Sections 1-4** must still be completed in their entirety by the patient.)

By fax:

- Complete this Enrollment Form and have your doctor sign it
- Have your doctor fax the completed form to: 1-855-284-0572

By mail:

- Physician: mail completed Enrollment Form with patient's original prescription to Eagle Pharmacy (see address on the previous page)

ePrescribing:

- Physician: ePrescribe in your system to Eagle Pharmacy
  Name: Eagle Pharmacy
  Location: Lakeland, FL
  NPI #: 1487905840
  NCPDP #: 5711975

Healthcare Provider Information

(To be completed by the healthcare provider.)

Full name _____

NPI #_____ Phone _____

Physician fax number _____

Prescription information

Drug name: MOBIC

Strength _____ Days' supply _____

Number of refills _____

Date written _____

Directions _____

Physician signature _____

Please see full Prescribing Information, including Medication Guide, for MOBIC available at MobicDoorToDoor.com

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