

Terms, Conditions and Eligibility Requirements: Eligible Patients must have a valid prescription for AJOVY[®] (fremanezumab-vfrm) injection. No substitutions permitted. Eligible Patients must have commercial prescription insurance administered through a pharmacy benefit plan. This Program does not cover AJOVY dispensed or administered under commercial insurance as adjudicated under a medical plan. Uninsured and cash-paying patients are NOT eligible for this Program. Patients enrolled in any state or federally funded healthcare program, including but not limited to, Medicare, Medigap, Medicaid, VA, DOD, TRICARE, Puerto Rico Government Health Insurance Plan, Medicare-eligible patients enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees, are NOT eligible for this Program. Cash Discount Cards and other noninsurance plans are not valid as primary under this Program. This Program is restricted to residents of the United States and United States territories.

Patients may pay as little as \$15 out of pocket for AJOVY[®]. Maximum Program assistance per prescription and annual benefit limits per individual apply and out of pocket expenses may vary. Patient is responsible for costs above maximum benefit amounts. Patients with managed care restrictions (e.g., prior authorization, step edit) may not be eligible for this Program if such managed care restrictions persist. Continued eligibility may require that the patient has an approved prior authorization. Patients without formulary coverage or an approved prior authorization for AJOVY may receive less benefit. Data related to an Eligible Patient's receipt of Program benefits may be collected, analyzed, and shared with Teva Pharmaceuticals USA, Inc. and its affiliates ("Teva"), for market research and other purposes (including with the patient's treating physician towards helping to verify or coordinate insurance coverage or otherwise obtain payment for the patient's treatment with AJOVY) related to assessing the Program. Data shared with Teva will be aggregated and de-identified, meaning it will not identify Eligible Patients.

This Program is not insurance. Void if copied, transferred, purchased, altered, or traded and where prohibited and restricted by law. The Program is not transferable. No substitutions are permitted. The Program form may not be sold, purchased, traded, or counterfeited. Void if reproduced. The Program benefit cannot be combined with any other financial assistance program, free trial, discount, prescription savings card, or other offer. This Program is managed by Paysign on behalf of Teva Pharmaceuticals USA, Inc. Teva reserves the right to make eligibility determinations, to set Program benefit maximums, to monitor participation, and to change, rescind, revoke, or discontinue this Program at any time without notice. If you have any questions regarding this Program, your eligibility or benefits or if you wish to discontinue your participation, please call 1-844-309-5477. These Terms and Conditions are valid for AJOVY[®] dispensed between 1/1/2025 and 12/31/2025. **Expiration Date: 12/31/2025.**

To the Patient: By participating in this Program, you acknowledge that you are an Eligible Patient and you understand and agree to comply with the Terms and Conditions of this Program.

This Program is for eligible **Commercially Insured Patients only**. Patients may pay as little as \$15 out of pocket for AJOVY[®]. Maximum Program assistance per prescription and annual benefit limits per individual apply and out of pocket expenses may vary. This Program must be presented along with your prescription for AJOVY and your primary insurance card to participate in this Program. Non-Insured/Cash-Paying Patients are not eligible for this Program.

To the Pharmacist: When you apply this Program, you are certifying that AJOVY[®] is being dispensed to an Eligible Patient in compliance with these Terms and Conditions and the Pharmacy has not submitted and will not submit a claim for reimbursement under any federal, state, or other governmental program for this prescription. For **Commercially Insured Patients**, please submit this claim to the primary Third-Party Payer first, then submit the balance due to PDML as a Secondary Payer COB (coordination of benefits) with patient responsibility and a valid Other Coverage Code (e.g., 08). If the primary Third-Party Payer has denied coverage or requires a prior authorization, then submit the claim to PDML using a valid Other Coverage Code (e.g., 03). If the primary Third-Party Payer has denied the primary claim due to a Prior Authorization (PA) requirement, please initiate the PA process to help your patient continue to save on AJOVY prescriptions.

Reimbursement will be received from PDML. For questions, please call the Concierge line for AJOVY[®] at 1-844-310-4170, Monday – Friday, 9 AM – 8 PM ET.