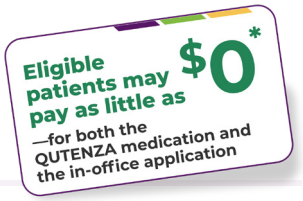
Qutenza® (capsaicin) 8% topical system

My QUTENZA Connect Cost Savings Program

Patient Reimbursement Request Form



Eligible patients can pay as little as $0 for QUTENZA treatment*—including the medication and in-office application—with the My QUTENZA Connect Cost Savings Program. Whether your healthcare provider (HCP) orders QUTENZA directly or sends the prescription to a specialty pharmacy, the Patient Cost Savings Program can help cover your out-of-pocket costs.

*Up to $5,000 in annual savings for medication and $1,500 in annual savings for administration.

Check your eligibility—you may be eligible for the Cost Savings Program if you:

- Are using QUTENZA for an FDA-approved use (diabetic nerve pain of the feet or post-shingles nerve pain)
- Are 18 years of age or older
- Have commercial (private) insurance that covers QUTENZA
- Live and receive treatment in the United States
- Do not use a state or federal healthcare plan to pay for your medication—this includes, but is not limited to, Medicare, Medicare Part D or Medicare Advantage, Medicaid, and TRICARE

Please see full terms and conditions on the next page or visit: qutenza.com/save-on-qutenza-treatment/

Who should receive the reimbursement? (select one)

◯ **Patient to be reimbursed:** I have paid my provider and would like the reimbursement sent to me.
- Complete **SECTION A** only. Submit this form with proof of payment receipt from the specialty pharmacy and/or your provider's office plus an Explanation of Benefits (EOB) from your insurance provider.

◯ **Provider to be reimbursed:** I have not paid for my treatment yet. Please send the reimbursement directly to my provider.
- Patient should complete **SECTION A** and your provider should complete **SECTION B**. Submit appropriate documentation as outlined in **SECTION C**.

SECTION A. Patient must complete this section.

First name: _____ Last name: _____

Date of birth: ____/____/____ Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: ____/____/____

☐ By signing above, you attest that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by your insurance, Flexible Spending Account (FSA), Health Savings Account (HSA), or any other payer. You attest that you are not covered under Medicare, Medicare Part D, Medicare Advantage, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD), or any other government (state or federally funded) program, and you understand that you are liable for any misrepresentations herein to the full extent of applicable law. You attest that the use of QUTENZA is for an FDA-approved use. Please see page 2 for full Terms and Conditions.

☐ By checking this box and signing the above, you also agree that your information can be used to send you additional marketing communications from Averitas. You understand that your eligibility for or enrollment in the My QUTENZA Connect Cost Savings Program is not contingent on your consent to receive marketing communications, and that you can opt out from receiving these messages at any time.

SECTION B. Provider must complete this section only if the office is getting reimbursed.

Date of QUTENZA treatment: ____/____/____

Administering HCP name: _____ Practice NPI #: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____ Office phone: _____

Authorized office staff name: _____ Signature: _____

☐ By signing above, you attest that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by the patient's insurance, Flexible Spending Account (FSA), Health Savings Account (HSA), or any other payer. You attest that the patient is not covered under Medicare, Medicare Part D, Medicare Advantage, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD), or any other government (state or federally funded) program, and you understand that you are liable for any misrepresentations herein to the full extent of applicable law. You attest that the use of QUTENZA for this patient is for an FDA-approved use. Please see page 2 for full Terms and Conditions.

SECTION C: Submission instructions.

The patient or provider should submit this form and a copy of the patient's insurance Explanation of Benefits (and proof of payment, if required). Submit via (select one):

◯ **Email:** claim.support@IQVIA.com
◯ **Fax:** 631-822-2893
◯ **Mail: IQVIA, Inc., Attn: Claims Processing Dept.,** 430 Mountain Avenue, Suite 105, New Providence, NJ 07974

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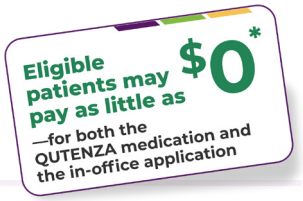

Terms and Conditions:

By using this offer, you (patient, HCP, or specialty pharmacy) confirm that you (or the patient) currently meet all eligibility criteria and will comply with all terms and conditions, as described below:

1. The My QUTENZA Connect Cost Savings Program (the "Program") is available only to eligible adult patients prescribed QUTENZA for use consistent with approved indications in US product labeling for QUTENZA. Eligible patients must reside in the US, Puerto Rico, or the US territories based on the patient's address. Eligible patients must be insured by a commercial insurer that (i) covers QUTENZA (including commercial plans from the Health Insurance Marketplace and plans under the Federal Employee Health Benefit [FEHB] Program) and (ii) does not prohibit participation in patient assistance programs. Uninsured patients or cash-paying patients and patients with coverage for QUTENZA through federal- or state-funded government healthcare programs, including Medicare, Medicare Part D or Medicare Advantage plans, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD), are not eligible for the Program. A patient who begins receiving benefits for QUTENZA from a government healthcare program will no longer be eligible for the Program.

2. When requesting reimbursement for charges that have already been paid, the Program will only accept applications from the patient and requests must be submitted via mail, email, or fax. Applications must be fully completed based on the instructions stated on the Patient Reimbursement Request Form. Averitas Pharma, Inc., is not responsible for lost, late, damaged, misdirected, incomplete, or illegible submissions. All submissions become the property of Averitas Pharma, Inc., and its agents. Please retain copies of any materials you submit.

3. Any refund under this Program may not exceed the eligible patient's medication and/or administration co-payment, co-insurance, or deductible costs ("Patient Responsibility") for QUTENZA, whether covered under the medical or pharmacy benefit. For pharmacy claims associated with the medication, this offer can be used only with a valid QUTENZA prescription at the time the prescription is filled by the pharmacist and dispensed to the patient, and is good only at participating pharmacies in the US.

4. The Program is valid for the patient's out-of-pocket costs for the medication and cannot be used if the patient is eligible to be reimbursed for the entire cost of QUTENZA. The patient and the patient's healthcare provider may not seek any other reimbursement of Patient Responsibility for the medication.

5. The Program is valid for the patient's total out-of-pocket costs for the administration of QUTENZA and cannot be used if the patient is eligible to be reimbursed for the cost of the administration of QUTENZA. The patient and the patient's healthcare provider may not seek other reimbursement of Patient Responsibility for the administration of QUTENZA. Applications for the full refund for the administration of QUTENZA are not eligible for the Program and will not be approved if the healthcare provider's administration costs are not covered or reimbursed by the patient's insurance.

6. Commercial insurers may use so-called "accumulator programs" that will prevent the out-of-pocket costs that are covered by the Program from being applied toward a patient's deductible or out-of-pocket cap. Please be aware, this may result in an additional charge to the patient even after the Program has been applied to the patient's out-of-pocket costs for QUTENZA.

7. Patient Responsibility for the medication must be isolated on the claim and separate from other services and products. A patient may not apply for reimbursement of Patient Responsibility under the Program if the patient's healthcare provider has already sought reimbursement under the Program, and the patient's healthcare provider may not seek such reimbursement of Patient Responsibility under the Program if the patient has already applied for reimbursement under the Program.

8. Refunds will be processed in the order in which they are received. Approved claims will be processed and paid in the subsequent billing cycle. Please allow approximately 4 weeks for delivery of refund checks. Tampering with, altering, or falsifying payment information is prohibited by law.

9. The Program is effective as of July 1, 2025. Any requests for cost savings must be adjudicated within 12 months of the date of service. This offer is valid for the eligible patient only. No other purchase is necessary. This offer has no cash value and cannot be combined with any other patient assistance program, free trial, discount, prescription savings card, or other offer. Averitas Pharma, Inc., reserves the right to cancel, modify, or rescind this Program at any time. Aggregate and non-identifiable patient information may be used by Averitas Pharma, Inc., for market research and other related purposes. This Program is not insurance and is not intended to substitute for insurance. This offer is void where prohibited or restricted by law.

The My QUTENZA Connect Cost Savings Program is used only in conjunction with a commercial payer.

Questions? Call 833-295-3579

*Up to $5,000 in annual savings for medication and $1,500 in annual savings for administration.

The categories of personal information collected in this form include name, date of birth, and treatment details. The personal information collected will be used for reimbursement form submission and eligibility approval for the MQC Cost Savings Program and to perform research analytics on a de-identified basis. For more information about the categories of personal information collected by Averitas and the purposes for which Averitas uses personal information visit: https://www.averitaspharma.com/privacy-statement/

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