

MAIL THIS TO YOUR INSURANCE PROVIDER

LETTER TO HEALTH PLAN



To whom it may concern:

I am an enrollee in your prescription drug plan, and this letter is to advise you that I have been prescribed CEQUA® (cyclosporine ophthalmic solution) 0.09% by my physician. I am purchasing this product outside of my insurance benefit with the CEQUA® and PhilRx Program sponsored by SUN Pharma.

This letter is not a request for reimbursement, as I have agreed to not seek reimbursement for my purchase in accordance with the Terms and Conditions of the CEQUA® and PhilRx Program. I am an enrollee in Medicare Part D or a Medicare Advantage prescription drug plan. I also have agreed that I will not count my purchases toward my true out-of-pocket expenses (TrOOP), and I will continue to use the CEQUA® and PhilRx Program for as long as I take the medication during the calendar year.

If you have questions about the medication or the CEQUA® and PhilRx Program, please contact PhilRx at [\[1-855-977-0975\]](tel:1-855-977-0975).

Sincerely,

NAME

DATE

DATE OF BIRTH

PRESCRIPTION PLAN

PRESCRIPTION PLAN MEMBERSHIP ID NUMBER