

## Savings Card

**SAVE**  
**\$50**  
up to  
**AFTER PATIENT  
PAYS FIRST \$15**

**SAVINGS  
CARD VALID  
FOR ONE  
OR BOTH  
PRODUCTS**

Products  
prescribed  
separately

**Texacort<sup>®</sup>**  
**Topical Solution 2.5%**  
HYDROCORTISONE TOPICAL SOLUTION

**SAVE**  
**\$40**  
up to  
**AFTER PATIENT  
PAYS FIRST \$15**

**Eletone<sup>®</sup> Cream**  
**with Hydrolipid Technology™**  
*Nonsteroidal Atopic Dermatitis Therapy*

**Instantly reduce your out-of-pocket cost with the Savings Card below.**

### Patient Instructions:

- 1 Present this coupon to your pharmacist with your prescription.
- 2 Keep this coupon for future use. It can be used up to 12 times.
- 3 You will be responsible for the first \$15 of your out-of-pocket expense for each fill.
- 4 You will then receive up to \$50 off your remaining out-of-pocket expense for Texacort and \$40 off your remaining out-of-pocket expense for Eletone Cream. You will be responsible for any additional out-of-pocket costs if it exceeds this amount.
- 5 Be sure to follow your doctor's instructions on how to use these therapies.

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Utilize the information below when submitting a claim to **Therapy First Plus**:

**BIN# 004682 Group ID: LCLYC374**  
**RxPCN: CN ID#: LYC195842976**

Please see full  
Prescribing Information  
at [missionpharmaceutical.com](http://missionpharmaceutical.com)

## Savings Card

**TEXACORT® CONTRAINDICATIONS:** Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation. **INFORMATION FOR THE PATIENT:** Patients using topical corticosteroids should receive the following information and instructions: **1.** This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes. **2.** Patients should be advised not to use this medication for any disorder other than for which it was prescribed. **3.** The treated skin area should not be bandaged or otherwise covered or wrapped as to be occlusive unless directed by the physician. **4.** Patients should report any signs of local adverse reaction especially under occlusive dressing. **5.** Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.

**ELETONE® CREAM CONTRAINDICATIONS:** THIS PRODUCT SHOULD NOT BE USED DURING THE PERIOD OF TIME WHEN RADIATION TREATMENT IS OCCURRING BECAUSE OF THE INCREASED RISK OF SKIN TOXICITY WHEN RADIATING THROUGH PETROLATUM AND OIL. ELETONE® CREAM is contraindicated in patients with a known hypersensitivity to any of the components of the formulation.

### Important Notice:

**Pharmacist: Therapy First Plus** has been authorized to reimburse you up to \$50 on TEXACORT® and \$40 on ELETONE CREAM of the patient's out-of-pocket expense after the patient pays an initial \$15 out-of-pocket expense. For reimbursement, please follow the instructions below: **For a Patient Paying Cash:** Please submit this claim to **Therapy First Plus**. A valid other coverage code is required. The patient's payment will be reduced by up to \$50 for TEXACORT and \$40 for ELETONE CREAM after they have paid an initial out-of-pocket cost of \$15 and you will receive this in your next reimbursement from **Therapy First Plus** plus a handling fee. **For a Patient Paying with an Authorized Third Party:** Submit the claims to the Primary Third Party Payer first, then submit the balance due to **Therapy First Plus**, as a Secondary payer as a co pay billing using Other Coverage Code Indication. The patient's payment will be reduced by up to \$50 for TEXACORT and \$40 for ELETONE CREAM after they have paid an initial out-of-pocket cost of \$15 and you will receive this in your next reimbursement from **Therapy First Plus** plus a handling fee. Other Coverage Code Indication Required.

Cannot be combined with any other offers.

**Available by prescription only.**

**Please see Full Prescribing Information available at [missionpharmaceutical.com](http://missionpharmaceutical.com)**



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**Eligibility Criteria:** **1.** This coupon is not valid for prescriptions purchased under Medicaid, Medicare, TRICARE, Federal or state programs including any state prescription drug programs), or private indemnity or HMO insurance plans which reimburse you for the entire cost of your prescription drugs. **2.** Coupon is limited to 1 per patient for up to 12 uses per coupon and is not transferable. **3.** Offer good only in the U.S. and Puerto Rico. **4.** Mission Pharmaceutical reserves the right to rescind, revoke or amend this offer without notice. **5.** You understand and agree to comply with the terms and conditions of this offer as set forth above. Offer void in Massachusetts. Void if prohibited by law, taxed or restricted. **Pharmacists only:** For any questions regarding **Therapy First Plus** online processing, please call the Help Desk at 1-800-422-5604. If your pharmacy is not part of the contractual network, please contact your headquarters and ask them to contact **Therapy First Plus**. I certify that I have received this coupon from an eligible person and have dispensed the product as indicated. I certify that my participation in this program is in compliance with all applicable state laws and my obligation, contractual or otherwise, that I have as a pharmacy provider. I also agree to retain the coupon for 3 years or as otherwise required by law, whichever is longer, and to grant Mission Pharmaceutical the right to audit any of my submissions.

**Available by prescription only. Products prescribed separately.**

**Please see Full Prescribing Information.**

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