

# MaxBack Program

## Satisfaction or Your Money Back

Take MAXALT® (rizatriptan benzoate) or MAXALT-MLT® (rizatriptan benzoate) as prescribed by your doctor for at least 2 migraine attacks. If you would like to keep track of your migraines, a downloadable diary is available at maxalt.com. If, after treating at least 2 attacks with MAXALT or MAXALT-MLT, you are not satisfied with the treatment, you may be eligible to receive your money back for 1 qualifying prescription, up to \$150. Not all patients are eligible. Please see Terms & Conditions.

### If you are eligible for a refund, follow these 4 steps:

1. Save your original pharmacy receipt indicating that the product you purchased was MAXALT or MAXALT-MLT, the date that prescription was filled, and the price that was paid.
2. Complete the Reimbursement Request Form below. The form must include your Prescriber's information and original signature. No signature stamps will be accepted.
3. Sign and clearly print your name and mailing address.
4. Mail your original pharmacy receipt and completed Reimbursement Request Form to:  
MAXBack Program • PO Box 720 • Horsham, PA 19044-6985

If you are eligible, the reimbursement check will be issued 6 to 8 weeks after we receive the Reimbursement Request Form. *Please note that each patient is eligible for only 1 reimbursement for 1 qualifying prescription of MAXALT or MAXALT-MLT, purchased between March 1, 2011 and June 30, 2012. Reimbursement Request Forms must be postmarked by September 28, 2012.* Patients who have previously received a reimbursement under any MAXBack Program are not eligible for additional reimbursements. Please call 1-888-MAX-6468 (8:00 AM to 8:00 PM ET, Monday through Friday) if you have questions about this offer.

MAXALT is a prescription medicine for the treatment of migraine attacks in adults. Only your health care professional can determine if MAXALT is right for you.

**Phenylketonurics:** MAXALT-MLT contains phenylalanine. Please read the Patient Product Information available at maxalt.com.

### Important Safety Information

- You should not take MAXALT if you have uncontrolled high blood pressure, heart disease or history of heart disease, or if you are taking or have taken MAO inhibitors within the last 2 weeks, or are taking certain other medications.
- Tell your doctor about all medications you are taking.
- Talk to your doctor about any history of chest pain, shortness of breath, or stroke.
- If you have risk factors for heart disease, such as high blood pressure, diabetes, high cholesterol, obesity, smoking, are postmenopausal, or are a male over 40, you should be evaluated by your doctor before taking MAXALT.
- Do not take MAXALT if you are pregnant or nursing.
- As with other drugs in this class, there have been very rare reports of heart attack and stroke generally occurring in patients with risk factors for heart and blood vessel disease.
- In clinical studies with MAXALT, the most common side effects reported were dizziness, sleepiness, tiredness, fatigue, and pain or pressure sensation (eg, in the chest or throat). Ask your doctor to discuss with you the more complete list of side effects reported with MAXALT.

**Please read the Patient Product Information at maxalt.com and discuss it with your doctor. Also available is the physician Prescribing Information.**

**Maxalt**  
(rizatriptan benzoate)

**Maxalt-MLT**  
(rizatriptan benzoate)

## Terms and Conditions

### *In order to be eligible for a refund:*

- You must be 18 years of age or older.
- You must purchase your 1 qualifying prescription of MAXALT® (rizatriptan benzoate) or MAXALT-MLT® (rizatriptan benzoate) between March 1, 2011 and June 30, 2012.
- **You must have a co-payment or make a full cash payment for the prescription.**
- This reimbursement is valid for those with private insurance or cash-paying patients. **Not valid for patients covered under Medicaid, Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, and any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program.**
- **This reimbursement is void for Massachusetts residents if a third-party payer reimburses or pays any amount of the prescription price or otherwise provides coverage for MAXALT or MAXALT-MLT.**
- This reimbursement can be used only by eligible US residents, and your receipt must be from an eligible retail or mail-order pharmacy in the United States. Product must originate in the United States.
- You must submit the required documentation with this Reimbursement Request Form as described below.
- No other purchase is necessary.
- Reimbursement is valid only for 1 qualifying prescription of MAXALT or MAXALT-MLT. Prescriptions for MAXALT or MAXALT-MLT purchased before March 1, 2011 and after June 30, 2012, will not qualify for a reimbursement.
- The maximum amount for a reimbursement will be equal to the out-of-pocket cost paid for 1 prescription of MAXALT or MAXALT-MLT, not to exceed \$150.
- Reimbursement is not valid for any other products, other out-of-pocket costs listed on your submitted pharmacy receipt, or your Prescriber visit co-pay.
- Only the patient may request the reimbursement. The patient's Prescriber or health care professional may not request the reimbursement on behalf of the patient and may not receive the reimbursement directly from Merck.
- Patient is limited to one (1) reimbursement request submission, provided the patient meets eligibility requirements and Terms and Conditions.
- **This Reimbursement Request Form must be postmarked within 90 days of the program expiration date: June 30, 2012. Reimbursement Request Forms postmarked after September 28, 2012, will not be honored.**
- If the Terms and Conditions are met, the reimbursement will be paid to the patient submitting the reimbursement request.
- All information requested on the Reimbursement Request Form must be provided, and the certifications must be signed. Forms that are not filled out completely or are modified will not be eligible for a reimbursement. Patient must ensure that the Prescriber completes the Prescriber Certification and Consent portion of the form.
- Reimbursement request submission must include:
  - This original Reimbursement Request Form. This form must be filled out completely and may not be modified in any manner. This form must contain original signatures. No signature stamps will be accepted.
  - The original pharmacy receipt indicating that the product you purchased was MAXALT or MAXALT-MLT, the date the prescription was filled, and the price that was paid.
- This reimbursement is not transferable. No substitutions are permitted.
- This Reimbursement Request Form is void if reproduced and void where prohibited by law, taxed, or restricted.
- **It is illegal to sell, purchase, trade, or counterfeit this reimbursement form.**
- Patient, Pharmacist, and Prescriber agree not to seek reimbursement for all or any part of the benefit received by the patient through this offer. Patient is responsible for reporting receipt of reimbursement to any insurer, health plan, or other third party who pays for or reimburses any part of the prescription for which a reimbursement has been received.
- If a coupon or savings card was used for the prescription submitted for reimbursement, the pharmacy receipt must clearly reflect the actual cost paid by the patient after the coupon or savings card was applied.
- **This reimbursement is not insurance.**
- This Reimbursement Request Form is the property of Merck and must be turned in on request.
- Merck reserves the right to rescind, revoke, or amend this offer at any time without notice.
- **Expiration date: June 30, 2012.**

## Reimbursement Request Form

**PRESCRIBER CERTIFICATION AND CONSENT:** By signing below, I agree that my patient tried MAXALT® (rizatriptan benzoate) or MAXALT-MLT® (rizatriptan benzoate) for at least 2 attacks and that the prescription did not provide satisfactory treatment. I certify that I will not charge any fee to complete the Reimbursement Request Form.

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Prescriber's name (please print)

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Prescriber's signature (no signature stamps)

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Prescriber's phone number

**PATIENT CERTIFICATION AND CONSENT:** I understand that the information provided will be available to Merck Sharp and Dohme Corp. (Merck), a subsidiary of Merck & Co., Inc., and others working on behalf of Merck (including Telerx, a wholly owned subsidiary of Merck that serves as administrator for the program), whose access is necessary for data processing, eligibility verification, and follow up related to this reimbursement program. By signing below, I agree that Merck and others working on behalf of Merck are authorized to verify this information and use it to verify my compliance with the Program Terms and Condition, to verify my compliance with the terms and conditions of other money-back or savings offers in which I may seek to participate in the future, and to conduct fraud prevention processes.

I understand that I may be contacted by others working on behalf of Merck for additional information to process the request. The information I provide on or in support of this reimbursement will not be used, without my permission, for marketing purposes other than as described in this form, unless required by law.

For more information about how Merck protects personal information about you, please read our Internet Privacy Policy and Privacy Commitment for US patients, consumers, and caregivers, available at [merck.com/about/how-we-operate/privacy/](http://merck.com/about/how-we-operate/privacy/).

**I understand that I am eligible to receive a reimbursement for only the out-of-pocket cost that I actually paid and that the enclosed pharmacy receipt submitted accurately reflects my out-of-pocket cost.** I also certify that I have not sought and shall not seek reimbursement for the out-of-pocket costs I am submitting on the enclosed pharmacy receipt from any other party, including my insurer. I certify that no part of the costs associated with the prescription for which I am seeking reimbursement was or will be covered or reimbursed by a government program including Medicaid, Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, and any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program. I certify that I am an eligible US resident. I certify that if I am a resident of Massachusetts, no third-party payer reimbursed or paid any amount of the prescription price or otherwise provided coverage for MAXALT or MAXALT-MLT. I certify that I am the patient identified below and that I am 18 years of age or older. I certify that I took MAXALT or MAXALT-MLT as prescribed by my doctor for at least 2 attacks.

## Reimbursement Request Form *(continued)*

**I have read and understand the Terms and Conditions of this Reimbursement Program.** I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing below is true and correct.

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Patient's name (please print)

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Patient's signature

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Patient's mailing address

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Date

