



Patient name _____

If under 18 years old, Parent/Guardian name (please print): _____
 _____ Relationship Self Parent Guardian

Street _____

City _____ State _____ Zip _____

Phone _____ E-mail _____

Healthcare Professional name _____

Healthcare Professional phone _____

Prescription is for: 30 days 60 days 90 days

This is my: First order Repeat order

- I qualify for SolvayCARESSM. I have been diagnosed with cystic fibrosis. I take CREON[®] as part of my daily treatment plan.
- I certify that I (or the patient if I am the parent or guardian) am not currently participating in Medicare, Medicaid, or any federal or state health programs. I have read all the information provided in this package and understand the terms of this agreement. Please see restriction for residents of states of Massachusetts on coupon below.
- I hereby authorize Solvay Pharmaceuticals, Inc. to maintain the enrollment of the above-named patient in the SolvayCARESSM program. I understand that Solvay Pharmaceuticals, Inc. will use the health information I provide in order to administer benefits and for future communications with me about opportunities provided by Solvay Pharmaceuticals and /or information related to the products it markets. Solvay Pharmaceuticals will maintain the confidentiality of patient information to the extent that it will not be shared with any parties not directly involved with SolvayCARESSM and administration of the program. Solvay Pharmaceuticals reserves the right to withdraw or cancel this offer at any time without notice. I understand that products or benefits offered through SolvayCARESSM are subject to availability and do not constitute an entitlement.
- See Full Prescribing Information for CREON[®] at creon.com.
- I opt NOT to receive any free multivitamins, nutritional drinks or supplements.

Signature of Patient/Guardian _____ Date _____

I WOULD LIKE TO RECEIVE FREE:

Please select from the following items:

Multivitamins

(Check 1 box)

(NOTE: for infants and children, please consult your Healthcare Professional prior to selecting multivitamins)

Chewable Tablets

- Cherry - Vitamax[®]
- Grape - Vitamax[®]
- Orange - Vitamax[®]
- Bubblegum - SourceCF[®]

Liquid Drops

- Cherry - Vitamax[®]
- SourceCF[®]

Softgels - SourceCF[®]

and

Nutritional Drinks & Supplements

(Check 1 box)

(NOTE: for infants and children, please consult your Healthcare Professional prior to selecting any Nutritional Drinks or Supplements)

Nestle[®] Carnation Instant Breakfast (24 count)

- Plus (High Calorie) - Chocolate
- Plus (High Calorie) - Vanilla
- Plus (High Calorie) - Combination
- VHC (Very High Calorie) - Vanilla

RESOURCE[®] Products (27 count)

- Breeze - Orange
- Breeze - Wild Berry
- Breeze - Variety Pack
- 2.0 Vanilla

To receive your free bottle of multivitamins and free nutritional drinks, please follow these 4 simple steps:

1. Fill your prescription for a 30-day supply or more of CREON[®] (pancrelipase) Delayed-Release Capsules.
2. Complete the patient information at the top of the coupon. Select your choices at the bottom of the coupon.
3. Tape your original proof of purchase (detailed pharmacy receipt) over the top of the coupon. No copies accepted.
4. Mail this completed coupon to:

SolvayCARESSM
Solvay Pharmaceuticals, Inc.
901 Sawyer Rd.
Marietta, GA 30062

Eligible applicants will be shipped selected nutritional supplements along with another coupon.

Certain restrictions apply.

Each request must be accompanied by a current proof-of-purchase (detailed pharmacy receipt) for a 30-day supply or more of CREON[®]. All orders are based on availability. Out-of-stock items will be substituted with similar items. Offer is limited to 1 coupon per patient per month. All fields on this coupon must be completed for this offer to be valid. This coupon cannot be duplicated; only original forms will be accepted. Offer not valid for prescriptions eligible to be reimbursed, in whole or in part, by Medicare, Medicaid, any other federal or state program, or by private plans or other health or pharmacy benefit programs which reimburse you for the entire cost of your prescription drugs. Offer void in Massachusetts for residents whose prescriptions are covered in whole or in part by third-party insurance, or where otherwise prohibited by law.

Only valid for US citizens whose prescriptions are filled within the United States. Offer good only in the USA. Coupon is void where prohibited by law. Solvay Pharmaceuticals, Inc., reserves the right to withdraw or cancel this offer at any time without notice. Other conditions may apply.