



Save up to **\$30**
on your ClindaReach prescription



ClindaReach® Kit NDC #65880-503-02
(Clindamycin Phosphate Topical Solution USP, 1%*) Pledgets
*Equivalent to 1% (10 mg/mL) Clindamycin

Dear Patient,

I have written you a prescription for ClindaReach (Clindamycin Phosphate Topical Solution USP, 1%) with the Integrated EasyReach™ Accessory Applicator System. This rebate will help offset your out-of-pocket expenses when purchasing ClindaReach.

To obtain your rebate, please follow these instructions.

1. Purchase ClindaReach® with the Integrated EasyReach™ Accessory Applicator System and complete this mail-in certificate.
2. Attach the original pharmacy prescription receipt to this certificate. The pharmacy receipt must clearly indicate the product name and price. Unlabeled cash-register or credit-card receipts will not be accepted.
3. Before mailing them in, make a copy of this certificate and the pharmacy receipt for your records.
4. Mail this completed certificate with original pharmacy receipt to:

ClindaReach Rebate Program
PO Box 8606
Prospect Heights, IL 60070

Wholesaler/Order #

Bergen	834-205	Cardinal	3923489
Amerisource	4974010	McKesson	1699719

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Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ E-mail* _____

*By providing your e-mail address, you agree to receive promotional offers from DUSA Pharmaceuticals, Inc.

No duplication or reproduction of this certificate will be accepted. Group requests will not be accepted. Limit 1 rebate form per envelope. Offer good only in the United States and Puerto Rico. Not to exceed copay amount. Offer not valid if prescription purchased under Medicaid, Medicare, or other federal or state health care programs. For residents of Massachusetts, offer valid only for customers with no public or private prescription coverage (see Mass Gen Laws, ch 175H, sec 3). Offer void where prohibited by law, taxed, or otherwise restricted. This offer is subject to modification or cancellation without notice. Allow 8 to 10 weeks for delivery.

By signing this card, you certify that you have not purchased your prescription under Medicaid, Medicare, or other federal or state health care programs. If you are a resident of Massachusetts, you also certify that you have no public or private insurance coverage.

Patient signature _____ Date _____

For more information on how to obtain the ClindaReach system, call 1-877-811-3872, option 5.

Manufactured for Sirius Laboratories, Inc., a wholly owned subsidiary
of DUSA Pharmaceuticals, Inc.®, Wilmington, MA 01887

MKT-1389 Rev C