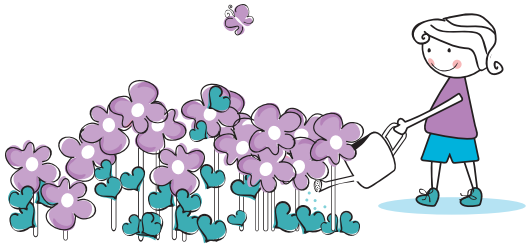

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$25 rebate for any co-pay or cash expense with your prescription of ProCentra™ (dextroamphetamine sulfate) Oral Solution (minimum quantity dispensed of 6 oz)

ProCentra™ (dextroamphetamine sulfate) Oral Solution

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2. Include a copy of your pharmacy information sheet listing your name, name of product, date, and amount paid.
3. Include a copy of your cash register receipt.
4. Mail this form, along with your pharmacy information sheet and cash register receipt to:

Tiber Laboratories
Rebate Department
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Suite 803
Suwanee, GA 30024

First Name _____

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By my signature above, I certify that I am not being reimbursed for this product by Medicare or Medicaid, any other federal or state program, including any state pharmaceutical assistance program or any other third-party payers. I also understand that I am responsible for any reporting or other requirements with respect to receipt of this rebate.

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