Phone: 844-INSPPRT (844-467-7778)
Website: www.INSUPPORT.com
Fax: 844-814-0669

COMMUNITY REENTRY PROGRAM ENROLLMENT FORM FOR SUBLOCADE® (buprenorphine extended-release)

Updated October 2022

To enroll, please complete and send all pages (1–4) of this form to enroll@insupport.com or fax to 844-814-0669

Community Reentry Program Patient Eligibility Requirements and Program Terms and Conditions

Patient Eligibility Requirements
The INSUPPORT Community Reentry Program's eligibility requirements include, but are not limited to, the following:

- The Community Reentry Program is available to patients for "on-label" use.
- Patient has applied for insurance coverage and is pending payer enrollment decision.
- Patient is a resident of the United States or U.S. territories.
- Patient is currently taking or was previously prescribed SUBLOCADE by his/her treatment provider.
- Patient has been given a certain release date or has been recently released from the criminal justice system.

Terms and Conditions
The Community Reentry Program provides transition of care for an eligible patient prescribed SUBLOCADE who is transitioning from a criminal justice facility to the community without access to health insurance upon release. The Community Reentry Program provides up to 2 months of product at no cost to enrolled patients while they obtain insurance coverage for SUBLOCADE. Patients must be currently receiving SUBLOCADE therapy and experiencing a gap in insurance coverage. Patients who have not yet received their first dose of SUBLOCADE are not eligible. Product provided through the Community Reentry Program at no charge is only available through a Community Reentry Program contracted pharmacy (INSUPPORT Network specialty pharmacy). Eligibility will be determined based on the Community Reentry Program eligibility requirements. INDIVIOR reserves the right to change or end the Community Reentry Program at any time, and other terms and conditions may apply.

STEP 1 Patient Contact Information

*First Name _____ MI _____ *Last Name _____ / / *DOB (MM/DD/YYYY) ☐ M ☐ F *Gender

*Address _____ *City _____ *State _____ *ZIP _____

( ) _____ *Primary Phone Number

*Email Address _____

Alternate Patient Contact (Optional)

Alternate Contact Name (please print) _____ Relationship to Patient _____ ( ) _____ Phone Number ☐ OK to leave a message

You may update your communication preferences or information provided during enrollment at any time by calling INSUPPORT at 844-INSPPRT (844-467-7778).

STEP 2 Patient Insurance Information

☐ Check here if the patient does not currently have insurance

☐ Check here if attaching a copy of the patient's insurance card(s). Please attach a copy of both sides of all applicable patient medical and prescription drug insurance cards

Please provide insurance information below (as much information as available) if coverage is pending.

☐ Private/Commercial ☐ Medicaid – State: _____ ☐ Medicare ☐ Other

Beneficiary/Cardholder Name _____ Relationship to Patient _____

Policy ID # _____ Group # _____ ( ) _____ Primary Insurance Phone Number

If patient has a separate prescription coverage plan, please add below. (Medicare patients please use Medicare Part D information.)

Pharmacy Benefit Plan Name (if applicable) _____ Policyholder Name _____ Relationship to Patient _____

Policy ID # _____ Rx Group # _____ Rx BIN _____ Rx PCN _____ ( ) _____ Pharmacy Benefit Plan Phone Number

STEP 2 Patient Insurance Information (Cont.)

If patient has active insurance coverage, INSUPPORT can route the patient's information to an INSUPPORT network specialty pharmacy (SP).

☐ **Route the Patient's Information to an INSUPPORT Network SP: See QR code for list**

Preferred SP: (Optional - Considered if SP is not payer-mandated) Pharmacy Benefit Plan Name (if applicable)

Network Specialty Pharmacy Locator

STEP 3 Provider Information

*Provider First Name | *Provider Last Name | *Provider NPI #

◯ Private Practice ◯ Outpatient Hospital/Clinic ◯ Inpatient Hospital ◯ Residential Treatment Facility

*Facility Type | Practice/Facility Name | Practice NPI #

*Practice Address | *City | *State | *ZIP

( ) *Practice Phone Number | ( ) *Practice Fax Number | Practice Contact First and Last Name | ( ) Practice Contact Phone Number

☐ Send all communications via email

Provider Email

STEP 4 Prescription Information (Attach your prescription if this form does not comply with state laws)

This prescription is only valid for free medications filled by an INSUPPORT dispensing pharmacy.

*Patient Name | MI | *Last Name | / / *DOB (MM/DD/YYYY) | *ICD-10 Diagnosis Code

*Patient Address | *City | *State | *ZIP

***Prescribed Dose (check one only)**

Dispense	Refill Amount
☐ SUBLOCADE® (buprenorphine extended-release) injection: 100 mg	☐ 1 Refill
☐ SUBLOCADE injection: 300 mg	

For a list of ICD-10 codes that may be used for appropriate SUBLOCADE patients, please see the Billing and Coding Guide

*Anticipated Injection Date / /

*Provider Name

*Provider Address | *City | *State | *ZIP

( ) *Provider Phone Number | ( ) *Provider Fax Number | *Provider NPI # | *Provider DEA # | *XDEA #

***Provider Signature** | *Date / /

(Dispense as written, substitution not allowed.)

STEP 5 Provider Attestation (Required)

By signing below, I certify the following:

1) The information inserted in this Enrollment Form has been provided exclusively by me (the provider named in this Form) or my office ("my Practice") and that information is accurate to the best of my knowledge; 2) Based solely on my professional judgment and determination of medical necessity as set forth herein, the prescribed medication is medically appropriate for the patient identified in the Patient Contact Information section of this Form (the "Patient"); 3) My Practice has obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all federal and state laws and regulations relating to medical and/or health privacy, including, but not limited to, the HIPAA Privacy Rule (codified at 45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (codified at 42 C.F.R. Part 2), as amended from time to time; 4) I have made no agreement, express or implied, to recommend, prescribe, or use INSUPPORT or any other product or service in exchange for the provision of any service provided through INSUPPORT on behalf of any patient; 5) I am willing to have INSUPPORT contact me for additional information relating to the INSUPPORT program, including via email, fax, telephone, or other means using my Practice Contact information provided in this Form; 6) I understand that completing this enrollment form does not ensure that the patient will obtain insurance coverage or reimbursement for the prescribed medication, and that the INSUPPORT program is provided for informational purposes only and does not constitute a statement, promise, or guarantee by INSUPPORT or Indivior Inc. of any nature; 7) I agree that in no event shall Indivior be liable for any damages resulting from or relating to requested or provided information from INSUPPORT; 8) I understand that I may be invited to participate in optional surveys regarding education and patient treatment; 9) I understand that Indivior Inc. reserves the right, at any time and without notice, to rescind, revoke, or amend the INSUPPORT program.

I (the prescriber) understand and agree that: I certify that the patient and physician information obtained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed SUBLOCADE® based on my professional judgment of medical necessity. Any medications supplied by INDIVIOR as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement. I have received the necessary legal authorization from the patient to transmit the patient's personal health information, for the purposes provided on this form, to INDIVIOR or its vendor affiliates. I authorize INSUPPORT to act on my behalf for the limited purposes of transmitting this prescription to the appropriate dispensing pharmacy. INSUPPORT may contact me for additional information relating to the Program, including but not limited to via email, fax, telephone, and text. I understand that the Community Reentry Program is designed to support patients who are experiencing a delay in obtaining insurance coverage for SUBLOCADE upon transition from the Criminal Justice System. I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I understand that neither I nor the patient may seek reimbursement for free product received under the program.

By signing below, I confirm that I have read, understand, and agree to the Provider Attestation.

***Provider Signature** _____ *Date ___/___/___

STEP 6 Patient Authorization for Use and Disclosure of Health and Personal Information

By signing below, **I authorize** (1) My treatment provider (including his/her staff, any affiliated group practices, and/or any provider I am referred to by my current treatment provider), (2) the health insurer(s) listed on my enrollment form, and (3) the specialty pharmacy to which my SUBLOCADE® prescription is sent for fulfillment **to use and to disclose** to Indivior Inc. (including any of its affiliates), and the companies working with Indivior Inc. (collectively "Recipients"), and for those Recipients to share among themselves, **my personal and medical information (my "Information")**, including, but not limited to, any information about me on this enrollment form and/or about my medical treatment with SUBLOCADE, for purposes of facilitating my enrollment in and participation in the INSUPPORT program. I further authorize the Recipients to share my Information among themselves, so that one or more of them can: a) administer and/or provide INSUPPORT program services or information related to my enrollment; b) conduct an insurance benefit verification and communicate my health insurance company's requirements for access to treatment with SUBLOCADE; c) coordinate and route information among Recipients to help in the coordination of my treatment with SUBLOCADE; d) provide me with educational or support services by mail, email, and/or telephone, which may include sending me product and/or treatment information; e) invite me to participate in optional surveys about my treatment, and/or; f) provide me with program information about, determine if I am eligible for, and help with my enrollment and continued participation in, the INSUPPORT Copay Assistance Program for SUBLOCADE and the Community Reentry Program. I understand that my specialty pharmacy may receive payment from Indivior Inc. in exchange for providing my Information per this authorization.

Signing this form is my choice. I understand that I do not need to sign this form in order to obtain treatment, insurance, or insurance benefits; I am required to sign it only if I wish to participate in the INSUPPORT program. Any communication conveying my mental health or drug treatment Information in reliance on this authorization must include a notice that such Information may not be shared further. I understand that my Information shared in reliance on this authorization might, once shared, no longer be subject to federal or state privacy laws and could be shared further.

I can revoke my authorization at any time by calling 844-INSPPRT (844-467-7778) or by mailing a signed written statement of my revocation to INSUPPORT at PO Box 50, Bearfoot Road, Northborough, MA 01532. I understand that such a revocation will not apply to uses or disclosures made before INSUPPORT receives my statement of revocation. If I do not revoke the authorization, it will expire two (2) years from the date I sign below, or upon such earlier date as may be mandated by state law. I have the right to receive a copy of this authorization after I sign it. I understand that I may refuse to sign this authorization and that refusing to sign this authorization will not change the way my physician, health insurance, and pharmacy providers treat me.

Patient Signature and Date Required

By signing below, I confirm that I have read, understand, and agree to this Patient Authorization.

*Patient Name (please print) _____

*Patient Signature _____ *Date ___/___/___