inSupport®

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

CRIMINAL JUSTICE SYSTEM
TRANSITION OF CARE ENROLLMENT FORM FOR SUBLOCADE® (buprenorphine extended-release)

Updated October 2022

To enroll, please complete and send all pages (1–3) of this form to enroll@insupport.com or fax to 844-814-0669

*Indicates required field

STEP 1 Coordinator Information

*Coordinator First Name

*Coordinator Last Name

Facility Name

*Facility Address

*City

*State

*ZIP

( ) *Facility Phone Number

( ) *Facility Fax Number

Coordinator Email

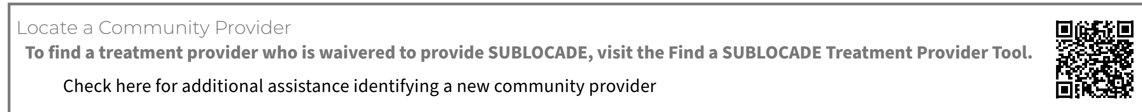
Send all communications via email

STEP 2 Treatment Information

*Last Injection Date: ___/___/______

*Prescribed Dose (check one only): SUBLOCADE 300 mg SUBLOCADE 100 mg

STEP 3 Transition of Care Information



Locate a Community Provider

To find a treatment provider who is waivered to provide SUBLOCADE, visit the Find a SUBLOCADE Treatment Provider Tool.

Check here for additional assistance identifying a new community provider

INSUPPORT will call the provider identified below to confirm the provider is accepting new patients

Private Practice Outpatient Hospital/Clinic Inpatient Hospital Residential Treatment Facility

*Facility Type

*Provider Name

*Provider NPI #

*Provider Address

*City

*State

*ZIP

( ) *Provider Phone Number

( ) *Provider Fax Number

___/___/______ Planned Discharge/Release Date

Post-Discharge Insurance

Check here if the patient will **not have** insurance

Please provide insurance information below (as much information as available) if the patient will have insurance post-discharge or if coverage is pending

___/___/______ Date Applied or Insurance Start Date

Private/Commercial Medicaid – State Medicare Other

Insurance Type

Primary Insurance Name

Beneficiary/Cardholder Name

Relationship to Patient

Policy ID #

Group #

( ) Insurance Phone Number

Indivior Inc. reserves the right to cancel, revoke, or change the INSUPPORT® program as they choose without prior notice.

NP-BAG-US-00807 EXPIRY September 2024

inSupport®

STEP 4 Coordinator Attestation (Required)

By signing below, I certify the following:

1) The information inserted in Steps 1, 2, 3, 4, and 5 (as applicable) of this Enrollment Form has been provided exclusively by me (the coordinator named in this Form) or my facility 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 facility 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 Facility 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.

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

***Coordinator Signature** ______________________ *Date ___/___/______

STEP 5 Patient Contact Information

*First Name ______ MI ______ *Last Name ______ *DOB (MM/DD/YYYY) ___/___/______ *Gender M F

Patient Address Post-discharge

*Address ______ *City ______ *State ______ *ZIP ______

( ) ______
Primary Phone Number

Alternate Patient Contact (Optional)

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

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

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. 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 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.

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 ___/___/______