inSupport®

INSUPPORT® PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

USER GUIDE

Updated January 2024

NP-RAG-US-00492 EXPIRY December 2025

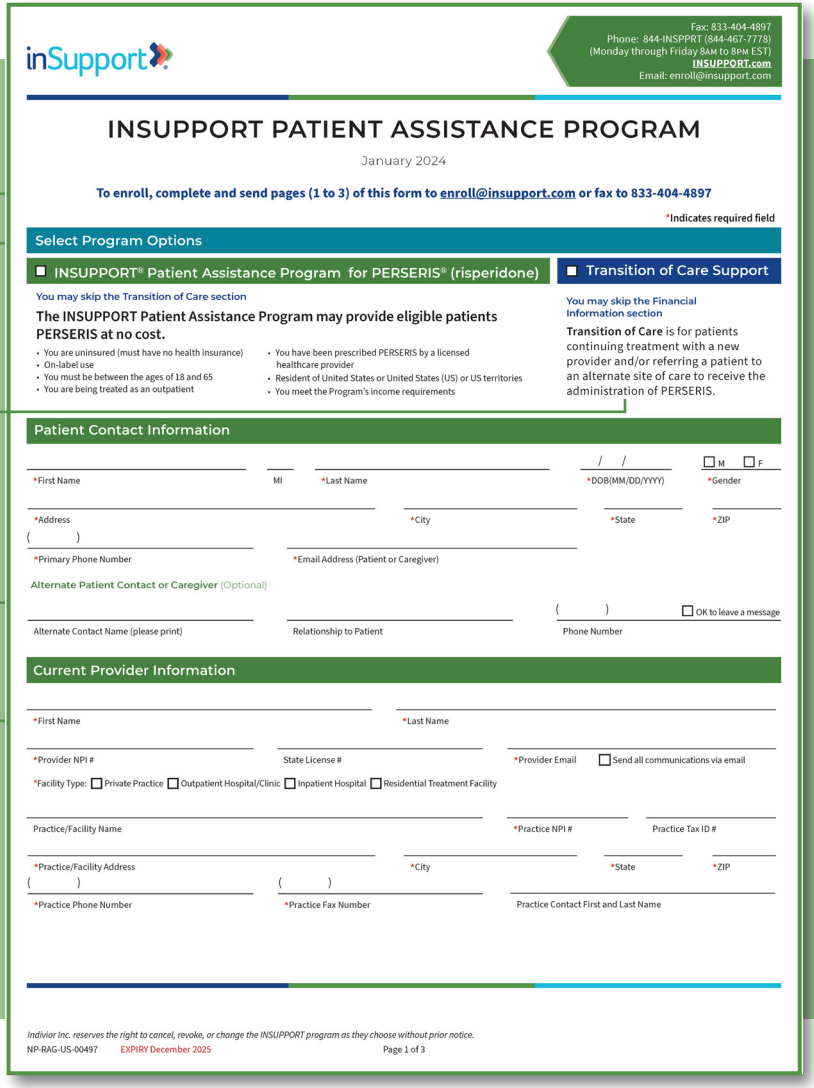
All required fields on this form are indicated with a red asterisk (*). Once all required information is completed on this form, send all pages (1-3) of this form to enroll@insupport.com or fax to 833-404-4897.

Select Program Options. For each program option, there is a description of the information provided by INSUPPORT® and the required steps to be completed on the form for patient enrollment. Please select all applicable options.

This option is only applicable to patients who will be leaving your site of care in the future and transitioning to a new healthcare provider. Learn more about Transition of Care Support by using this QR code.

Patient Contact Information: All patient contact information is required.

This information is required for enrollment and should reflect the enrolling treatment provider. If the patient will be transitioning to a new site of care, the new provider information should be provided on page 3. Please complete the practice contact information to indicate a specific person for INSUPPORT to contact regarding this case, if needed.



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Fax: 833-404-4897
Phone: 844-INSPPRT (844-467-7778)
(Monday through Friday 8AM to 8PM EST)
INSUPPORT.com
Email: enroll@insupport.com

INSUPPORT PATIENT ASSISTANCE PROGRAM

January 2024

To enroll, complete and send pages (1 to 3) of this form to enroll@insupport.com or fax to 833-404-4897

*Indicates required field

Select Program Options

☐ INSUPPORT® Patient Assistance Program for PERSERIS® (risperidone)

You may skip the Transition of Care section

The INSUPPORT Patient Assistance Program may provide eligible patients PERSERIS at no cost.

- You are uninsured (must have no health insurance)
- On-label use
- You must be between the ages of 18 and 65
- You are being treated as an outpatient
- You have been prescribed PERSERIS by a licensed healthcare provider
- Resident of United States or United States (US) or US territories
- You meet the Program's income requirements

☐ Transition of Care Support

You may skip the Financial Information section

Transition of Care is for patients continuing treatment with a new provider and/or referring a patient to an alternate site of care to receive the administration of PERSERIS.

Patient Contact Information

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

*Address | *City | *State | *ZIP

( ) *Primary Phone Number | *Email Address (Patient or Caregiver)

Alternate Patient Contact or Caregiver (Optional)

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

Current Provider Information

*First Name | *Last Name

*Provider NPI # | State License # | *Provider Email ☐ Send all communications via email

*Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Hospital ☐ Residential Treatment Facility

Practice/Facility Name | *Practice NPI # | Practice Tax ID #

*Practice/Facility Address | *City | *State | *ZIP

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

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

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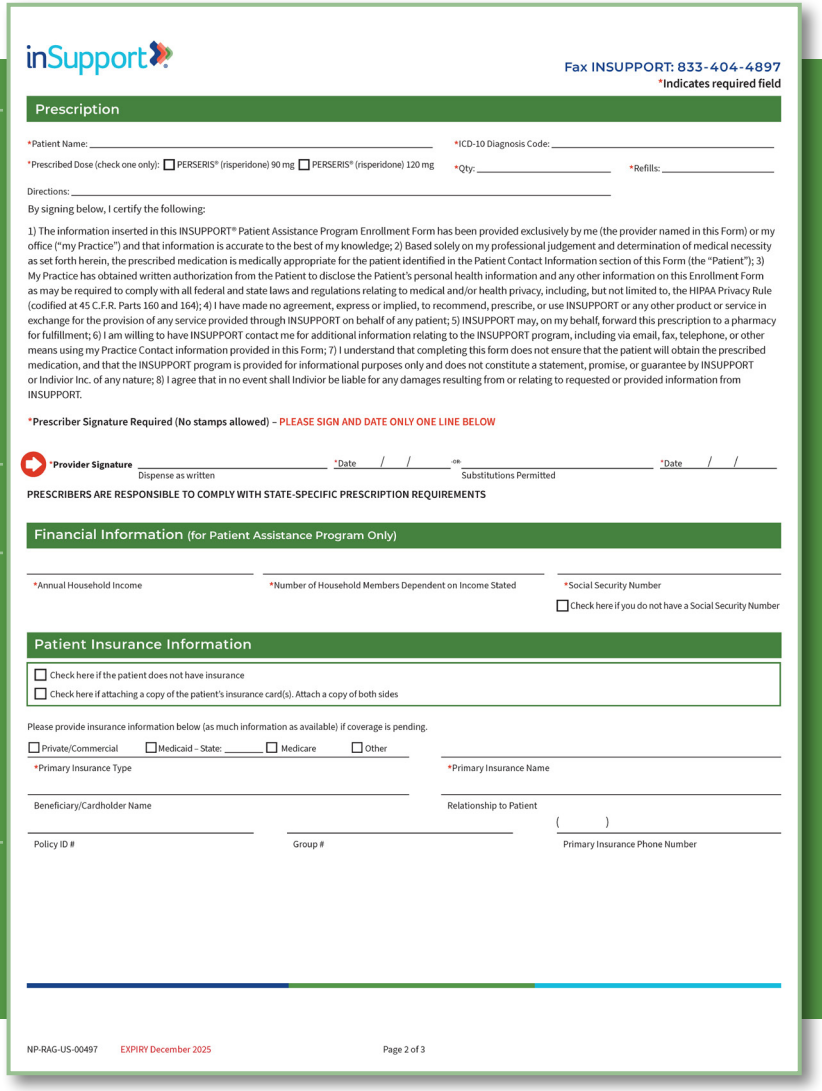
Prescription Information: The information in this section must be completed by the treatment provider and is necessary to validate FDA-approved use of PERSERIS® (risperidone), as well as for completion of the benefit investigation process with the patient's insurance provider, where applicable.

The treatment provider's signature and date are required to confirm the provider's agreement with the statements listed in this attestation related to participation with INSUPPORT.

Financial Information: For patients enrolled in the Patient Assistance Program only, provide information on the patient's financial annual household income, number of household members, and social security number. Please check the box if the patient does not have a social security number.

Patient Insurance Information: If the patient is not insured, please ensure you check the box indicating the patient does not have insurance. If the patient is insured and you have a copy of the patient's health insurance card(s) (front and back), please check the box indicating that the insurance information is attached and send it to INSUPPORT along with the enrollment form. If no copies are available, primary insurance information must be completed in this step. If the patient has both medical and pharmacy coverage, please provide information for both plans, if available.



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Fax INSUPPORT: 833-404-4897

*Indicates required field

Prescription

*Patient Name: _____ *ICD-10 Diagnosis Code: _____

*Prescribed Dose (check one only): ☐ PERSERIS® (risperidone) 90 mg ☐ PERSERIS® (risperidone) 120 mg *Qty: _____ *Refills: _____

Directions: _____

By signing below, I certify the following:

1) The information inserted in this INSUPPORT® Patient Assistance Program 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 judgement 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); 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) INSUPPORT may, on my behalf, forward this prescription to a pharmacy for fulfillment; 6) 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; 7) I understand that completing this form does not ensure that the patient will obtain 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; 8) I agree that in no event shall Indivior be liable for any damages resulting from or relating to requested or provided information from INSUPPORT.

***Prescriber Signature Required (No stamps allowed)** – PLEASE SIGN AND DATE ONLY ONE LINE BELOW

*Provider Signature _____ *Date ___/___/___ -OR- _____ *Date ___/___/___
Dispense as written Substitutions Permitted

PRESCRIBERS ARE RESPONSIBLE TO COMPLY WITH STATE-SPECIFIC PRESCRIPTION REQUIREMENTS

Financial Information (for Patient Assistance Program Only)

*Annual Household Income | *Number of Household Members Dependent on Income Stated | *Social Security Number

☐ Check here if you do not have a Social Security Number

Patient Insurance Information

☐ Check here if the patient does not have insurance
☐ Check here if attaching a copy of the patient's insurance card(s). Attach a copy of both sides

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

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

*Primary Insurance Type | *Primary Insurance Name

Beneficiary/Cardholder Name | Relationship to Patient

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

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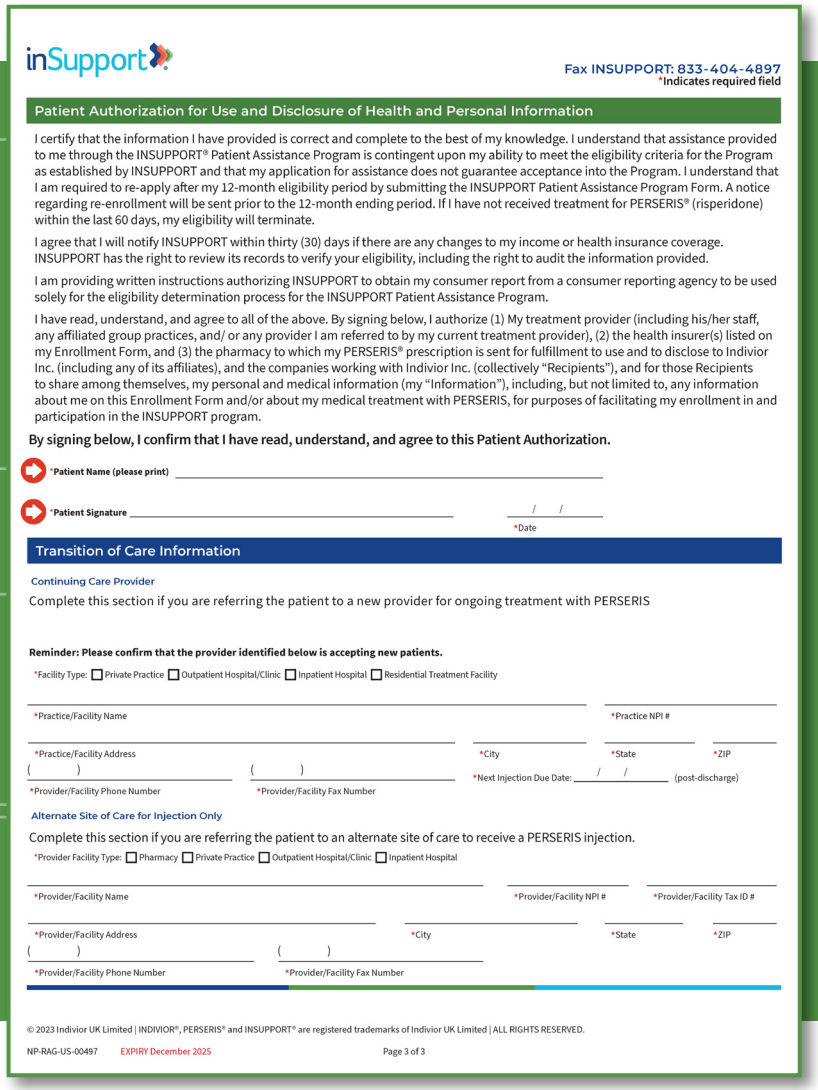
The patient should review this page prior to signing and dating the Authorization page. The Authorization includes, but is not limited to, details of why and to whom INSUPPORT® may use or disclose the patient's personal and medical information.

In order to initiate any request from INSUPPORT, the patient's name, signature, and date are required. Any Enrollment Form received by INSUPPORT with an incomplete Patient Authorization will be returned to the HCP for completion by the patient.

Transition of Care: For patients enrolled in Transition of Care only, provide the new continuing care provider information here. If you need more information on how to locate a new community provider for your patient, please contact INSUPPORT.

This date is required and should reflect the date that the patient's next injection of PERSERIS® (risperidone) is due after leaving your site of care.

This section is for patients who may need to receive a PERSERIS injection at an alternate site of care, please select the appropriate Provider/Facility Type.



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Fax INSUPPORT: 833-404-4897
*Indicates required field

Patient Authorization for Use and Disclosure of Health and Personal Information

I certify that the information I have provided is correct and complete to the best of my knowledge. I understand that assistance provided to me through the INSUPPORT® Patient Assistance Program is contingent upon my ability to meet the eligibility criteria for the Program as established by INSUPPORT and that my application for assistance does not guarantee acceptance into the Program. I understand that I am required to re-apply after my 12-month eligibility period by submitting the INSUPPORT Patient Assistance Program Form. A notice regarding re-enrollment will be sent prior to the 12-month ending period. If I have not received treatment for PERSERIS® (risperidone) within the last 60 days, my eligibility will terminate.

I agree that I will notify INSUPPORT within thirty (30) days if there are any changes to my income or health insurance coverage. INSUPPORT has the right to review its records to verify your eligibility, including the right to audit the information provided.

I am providing written instructions authorizing INSUPPORT to obtain my consumer report from a consumer reporting agency to be used solely for the eligibility determination process for the INSUPPORT Patient Assistance Program.

I have read, understand, and agree to all of the above. 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 pharmacy to which my PERSERIS® 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 PERSERIS, for purposes of facilitating my enrollment in and participation in the INSUPPORT program.

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

*Patient Name (please print) _____

*Patient Signature _____ ___/___/___ *Date

Transition of Care Information

Continuing Care Provider

Complete this section if you are referring the patient to a new provider for ongoing treatment with PERSERIS

Reminder: Please confirm that the provider identified below is accepting new patients.

*Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Hospital ☐ Residential Treatment Facility

*Practice/Facility Name _____ *Practice NPI # _____

*Practice/Facility Address _____ *City _____ *State _____ *ZIP _____

( ) _____ *Provider/Facility Phone Number ( ) _____ *Provider/Facility Fax Number

*Next Injection Due Date: ___/___/___ (post-discharge)

Alternate Site of Care for Injection Only

Complete this section if you are referring the patient to an alternate site of care to receive a PERSERIS injection.

*Provider Facility Type: ☐ Pharmacy ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Hospital

*Provider/Facility Name _____ *Provider/Facility NPI # _____ *Provider/Facility Tax ID # _____

*Provider/Facility Address _____ *City _____ *State _____ *ZIP _____

( ) _____ *Provider/Facility Phone Number ( ) _____ *Provider/Facility Fax Number