

INSUPPORT® Patient Authorization

Complete this form to provide authorization



Complete the **Patient Contact Information** section on page 1



Review and complete the Patient Authorization section on page 2



Review the Terms and Conditions on page 3



Have your healthcare provider fax the completed **Patient Authorization Form** (pages 1–2) to INSUPPORT 844-814-0669 or you can email the form to enroll@insupport.com

Patient Contact Information

_____		MI: _____	_____		_____	M	F
*First Name			*Last Name	*Date of Birth		*Gender	
_____		*City	*State	_____			
*Address			*ZIP Code				
_____		_____					
*Phone		*Email Address					

Alternate Patient Contact (Optional)

_____		_____	
Alternate Contact Name (please print)		Relationship to Patient	
_____		_____	
Phone		Email Address	

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

***Indicates required field**

Indivior Inc. reserves the right to cancel, revoke, or change any service that INSUPPORT provides, as they choose, without prior notice.

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® (buprenorphine extended-release) 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.

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 five 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: _____

Additional Options

COPAY ASSISTANCE PROGRAM FOR ELIGIBLE PATIENTS (Optional, sign and date to opt in)

By signing below, and accepting benefits under this Program, I certify that I have read, understand, and agree to the Terms and Conditions of the INSUPPORT Copay Assistance Program for SUBLOCADE and that I meet the Program’s eligibility requirements, to include, but is not limited to, the following:

- I am at least 18 years of age
- I have private health insurance
- I am not enrolled in, or covered by, any local, state, federal, or other government program that pays for any portion of medication costs, including, but not limited to Medicare, Medicaid, Medigap, VA, DOD, TRICARE, CHAMPVA, or any other federally or state-funded government-assisted program
- I am a resident of the United States or U.S. territories
- I have been prescribed SUBLOCADE by my treatment provider

COMMUNITY REENTRY PROGRAM FOR ELIGIBLE PATIENTS (Optional, sign and date to opt in)

By signing below, I certify that I have read, understand, and that I meet the Program’s eligibility requirements that include, but are not limited to, the following:

- I have applied for insurance coverage and it is pending payer enrollment decision
- I am a resident of the United States or U.S. territories
- I am currently taking or was previously prescribed SUBLOCADE by my treatment provider
- I have been given a certain release date or have been recently released from the criminal justice system

*Patient Signature: _____ *Date: _____

The INSUPPORT® Copay Assistance Program for SUBLOCADE® (buprenorphine extended-release) Terms and Conditions

To receive benefits under the INSUPPORT Copay Assistance Program, the patient must be determined as eligible and be enrolled in the Copay Assistance Program.

Patient Eligibility Requirements:

- Patient must have private health insurance that provides coverage for some portion of the cost of SUBLOCADE under a medical or pharmacy benefit plan. The Copay Assistance Program is not valid for uninsured patients.
- Patients with government insurance are not eligible for the Copay Assistance Program, including, but not limited to Medicare, Medicaid, Medigap, VA, DOD, TRICARE, CHAMPVA, or any other federally or state-funded government-assisted program.
- Patient is at least 18 years of age.
- The Copay Assistance Program is available to patients only for “on-label” use.
- Patient is a resident of the United States or U.S. territories, based on patient’s address.
- Patient is a resident of a state where copay assistance is not prohibited.
- Patient’s private insurance has not prohibited coupons/copay assistance for SUBLOCADE.
- Patient has been prescribed SUBLOCADE by his/her treatment provider.

Program Enrollment:

- Patient must request eligibility determination and enrollment for the Copay Assistance Program via the INSUPPORT Patient Enrollment Form or www.INSUPPORT.com/savings.
- Enrollment information that is modified or does not contain the information required will not be accepted by INSUPPORT for evaluation of Program eligibility.
- Copay member information may be provided to the patient via mail, email address, or mobile phone number for patients who opt in to text communications, provided during the enrollment. Patients may opt out of these notifications at any time by contacting INSUPPORT.
- Patient Authorization is required for INSUPPORT to enroll an eligible patient in the INSUPPORT Copay Assistance Program. Patient Authorization is:
 - Valid for five years from the date of signature.
 - Required to be provided each calendar year to continue receiving benefits, assuming all eligibility criteria continues to be met.
- The eligibility period for the Copay Assistance Program is based on calendar year (January through December).
 - Yearly re-enrollment is no longer required for the Copay Assistance Program.
 - Patients who enrolled in copay assistance can continue using the same copay card the following year of enrollment.
 - If a patient misplaced their copay card information, please have them contact INSUPPORT at (844) 467-7778 to obtain their copay card information over the phone.

Program Benefit and Conditions:

- Eligible patients may pay as little as \$0 per injection of SUBLOCADE throughout the eligibility period.
- Following the patient’s initial enrollment in the Program, and each subsequent calendar year the patient remains on SUBLOCADE and continues to meet the Program eligibility criteria, the patient will receive the following medication copay assistance:
 - The patient will receive an expanded benefit amount for the first two injections in the calendar year. The expanded benefit amount is up to \$2,016.52 for SUBLOCADE.
 - Following the first two injections of SUBLOCADE in the same calendar year, the patient will receive a maximum copay assistance amount of \$800 per injection for the remainder of the calendar year.
 - If patient’s financial responsibility for the medication is greater than the maximum benefit per injection, the patient will be responsible for any remaining costs not covered by the copay assistance benefit dollars.
 - Expanded benefit resets at beginning of each calendar year.
- The Program benefit may be applied for maximum of 14 injections per calendar year and requires that there must be a minimum of 23 days between dates of service. The maximum possible annual benefit is \$13,633.04.
- If SUBLOCADE is covered under the patient’s medical benefit plan:
 - An Explanation of Benefits (EOB) from patient’s private health insurer must be submitted within 180 days of the date of the EOB for patient to receive copay assistance benefit. The EOB must reflect the patient’s out-of-pocket cost for SUBLOCADE and submission of the claim by the patient’s provider for the cost of SUBLOCADE.
- The benefit available under the Copay Assistance Program is valid for the patient’s out-of-pocket cost for SUBLOCADE only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of SUBLOCADE. Claims for SUBLOCADE must be submitted by the provider to patient’s private health insurance separately from other services and products.
- Copay claims will be processed, and benefits applied, in the order in which they are received.
- Patient agrees not to seek reimbursement (in full or in part) from any insurer or payer, including a flexible spending or healthcare savings account, for any or all of the benefit received by the patient through the Copay Assistance Program.
- Patient agrees to notify INSUPPORT immediately if the patient’s health insurance status changes, or if the patient becomes entitled to, or enrolls in a government health insurance program/payer.
- The Copay Assistance Program benefit is non-transferable, limited to one person, and cannot be combined with any other Copay Assistance Program, free trial, discount, prescription savings card, or other offer. Offer has no cash value.
- Aggregated and non-identifiable information from patients participating in the INSUPPORT Copay Assistance Program may be collected, analyzed, summarized, and shared with Indivior Inc., and its affiliates for market research, statistical, and other purposes related to assessing the Copay Assistance Program.
- Indivior Inc. reserves the right to rescind, revoke, or amend the INSUPPORT Copay Assistance Program at any time without notice.
- The INSUPPORT Copay Assistance Program is not insurance.