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) | ☐ M ☐ F *Gender

*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

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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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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 _____

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

*Provider/Facility Phone Number *Provider/Facility Fax Number

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