inSupport®

INSUPPORT® Final Benefit Summary

User Guide

NP-BAG-US-00950 EXPIRY November 2025

The Summary of Benefits details will be populated by INSUPPORT® with information collected from the patient's insurance provider.

If the patient has health insurance coverage under more than one health plan, one of the plans will be designated as the "primary payer" on the enrollment form. INSUPPORT will research pharmacy and medical coverage on primary, secondary, and tertiary insurance benefit plans, if applicable.

The Benefit Summary first offers a snapshot of coverage for SUBLOCADE®(buprenorphine extended-release) or PERSERIS®(risperidone). Within this section, you will find information related to coverage, the benefit type, and any prior authorization requirements.

The product acquisition options (ie, Buy & Bill, Specialty Pharmacy, or Pharmacy), as determined by the patient's insurance providers, are communicated here.

If the patient's insurance provides additional coverage for food, lodging, or transportation, this section will include details about prior authorization requirements, types of services offered, and the amount available to the patient.

Summary of Benefits

inSupport

Patient Name:	Patient DOB:	HUB ID#:
Prescriber Name:	Date of BI Completion:	

Summary Page

Product Name: [Insert Product Name]
[SUBLOCADE® (buprenorphine extended-release), PERSERIS® (risperidone)]

Provider Network Status:	**<In-Network, Out-of-Network>**		
Is Product Covered for PBM?	**<Covered, Covered w/Approved PA, Covered w/Step Edit, Not Covered>**		
Is Product Covered for Medical?	**<Covered, Covered w/Approved PA, Covered w/Step Edit, Not Covered>**		
Is PA Required for PBM?	<Yes/No>	**PBM PA Requirements:**	<Pull from PBM PA Req's>
Is PA Required for Medical?	<Yes/No>	**Medical PA Requirements:**	<Pull from Medical PA Req's>
How is PA Submitted for PBM?	<Phone, Fax, CoverMyMeds, Website, Other>		
How is PA Submitted for Medical?	<Phone, Fax, CoverMyMeds, Website, Other>		
Patient PBM Plan	<Plan>	**Patient [PRODUCT] OOP (PBM)**	<PBM Copay Amount>
Patient Medical Plan	<Plan>	**Patient [PRODUCT] OOP (Medical)**	< Copay Amount>
Is the Patient Eligible for Copay Assistance?	<Yes/No>	**Copay ID**	<Copay ID>
Options for Procure:	**<Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>**		
Food:	<Yes/No, PA required, Type of Service, Amount>		
Lodging:	<Yes/No, PA required, Type of Service, Amount>		
Transportation:	<Yes/No, PA required, Type of Service, Amount>		

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The Specialty Pharmacy Information section will only appear on the Final Benefit Summary if INSUPPORT has routed the patient's information to a Specialty Pharmacy. This informs the healthcare provider (HCP) of which Specialty Pharmacy has received the patient's information and where the HCP needs to send the patient's prescription. The HCP should promptly send the patient's prescription to the Specialty Pharmacy listed here in order to help reduce delays. Once the prescription is sent, it will be linked to the patient's routed information from INSUPPORT and the Specialty Pharmacy will then begin processing the request for medication.

This section will provide the specifics of the patient's primary pharmacy coverage for medications. This will appear only if the product is covered by the patient's health insurance company under the pharmacy benefit.

This section informs the HCP of any coverage restrictions, such as quantity limits or step edits, that may be imposed by the patient's insurance provider.

Patient Name:	Patient DOB:	HUB ID#:
Prescriber Name:	Date of BI Completion:	

Specialty Pharmacy Information

Can Prescriber Use an SP?	<Yes/No>	**Was the Case Triaged to SP?**	<Yes/No>
SP 1 Name:	<Insert SP Name>		
SP 1 Phone #:	<XXX-XXX-XXXX>	**SP 1 Fax #:**	<XXX-XXX-XXXX>
SP 2 Name:	<Insert SP Name>		
SP 2 Phone #:	<XXX-XXX-XXXX>	**SP 2 Fax #:**	<XXX-XXX-XXXX>
SP 3 Name:	<Insert SP Name>		
SP 3 Phone #:	<XXX-XXX-XXXX>	**SP 3 Fax #:**	<XXX-XXX-XXXX>
SP 4 Name:	<Insert SP Name>		
SP 4 Phone #:	<XXX-XXX-XXXX>	**SP 4 Fax #:**	<XXX-XXX-XXXX>

Primary Pharmacy Coverage Details

Payer Name:	<Payer Name>	**PBM Name:**	<PBM Name>
Payer Type:	<Medicare/Medicaid/Commercial>	**Design of Plan:**	<HSA, PPO, HMO>
Policy Holder:	<Policy Holder>	**Member ID:**	<ID #>
PBM Phone #:	<XXX-XXX-XXXX>	**Group #:**	<Group #>
BIN:	<BIN>	**Effective Date:**	<Date>
PCN:	<PCN>	**Term Date:**	<Date>
Deductible (Individual):	Individual: <Ind Ded Amt > Family: < Family Ded Amt>	**Copay Assistance Applied to Deductible:**	<Yes/No>
Deductible Met YTD:	Individual:<Yes/No> Family: <Yes/No>	**Copay Assistance Applied to OOP:**	<Yes/No>
Product Copay Amount:	<$+Copay >	**Product Coinsurance Amount:**	<Co-Ins+%, Not Applicable>
SubQ 96372 Copay:	<$+Copay>	**Administration Coinsurance:**	< Co-Ins+%>
[PRODUCT] Coverage:	<Covered, Covered w/Approved PA, Covered w/Step Edit, Not Covered>	**PA Dept. Phone #:**	<PA #>
PA Required:	<Yes/No>	**Approval #:**	<Approval #>
PA Start Date:	<mm/dd/yyyy>	**PA End Date:**	<mm/dd/yyyy>
Preferred Method of PA Submission:	<Phone, Fax, Email>	**PA Decision-Maker:**	<Plan/PBM>
Coding Requirements:	NDC: <Code> ICD Diagnosis Code: <Code> Other Diagnosis: <Code>	**Options for Procure:**	<Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>

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This section will provide the specifics of the patient's primary medical coverage for medications. This will appear only if the product is covered by the patient's health insurance company under the medical benefit.

This section details any prior authorization requirements from the patient's insurance company. INSUPPORT® may put additional notes in the PA Requirements section.

Patient Name:	Patient DOB:	HUB ID#:
Prescriber Name:	Date of BI Completion:	

Primary Medical Coverage Detail			
Payer Name:	<Payer Name>	**Plan Name:**	<Plan Name>
Payer Type:	<Medicare/Medicaid/Commercial>	**Plan Type:**	<HSA, PPO, HMO>
Policy Holder:	<Policy Holder>	**Member ID:**	<ID #>
Medical Plan Phone #:	<XXX-XXX-XXXX>	**Group #**	<Group #>
Effective Date:	<Date>	**Term Date:**	<Date>
Deductible:	Individual: <Ind Ded Amt > Family: < Family Ded Amt>	**Copay Assistance Applied to Deductible:**	<Yes/No>
Deductible Met YTD:	Individual: <Yes/No> Family: <Yes/No>	**Copay Assistance Applied to OOP:**	<Yes/No>
Product Copay Amount:	<$+Copay >	**Product Coinsurance Amount:**	<Co-Ins+%, Not Applicable>
SubQ 96372 Copay:	<$+Copay >	**Administration Coinsurance:**	<Co-Ins+%>
[PRODUCT] Coverage:	<Covered, Covered w/Approved PA, Covered w/Step Edit, Not Covered>	**PA Dept. Phone #:**	<PA #>
PA Required:	<Yes/No>	**Approval #:**	<Approval #>
PA Start Date:	<mm/dd/yyyy>	**PA End Date:**	<mm/dd/yyyy>
Preferred Method of PA Submission:	<Phone, Fax, Email>	**PA Decision-Maker:**	<Plan/PBM>
PA Requirements:	<PA NOTES>		
Plan Limitations Cap Limit:	<Yes/No>	**Plan Limitations Cap Amount:**	$<XXX.XX>
Plan Limitations Cap Amount Frequency:	<Annually/Monthly/Quarterly/Semi-Annually/Daily/Other>	**Plan Limitations Quantity Limit:**	<Number>
Plan Limitations Quantity Limit Met to Date:	<Number>	**Coverage Restrictions:**	<Coverage Restrictions>
Coding Requirements:	NDC: <Code> ICD Diagnosis Code: <Code> Other Diagnosis: <Code>	**Options for Procure:**	<Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>

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This section will provide the specifics of a secondary pharmacy plan, if available. Once the primary insurance coverage is applied, a secondary claim can be filed through this insurance plan. This information will appear only if applicable.

Patient Name:	Patient DOB:	HUB ID#:
Prescriber Name:	Date of BI Completion:	

Secondary Pharmacy Coverage Detail			
Payer Name:	<Payer Name>	**PBM Name:**	<PBM Name>
Payer Type:	<Medicare/Medicaid/Commercial>	**Design of Plan:**	<HSA, PPO, HMO>
Policy Holder:	<Policy Holder>	**Member ID:**	<ID #>
PBM Phone #:	<XXX-XXX-XXXX>	**Group #:**	<Group #>
BIN:	<BIN>	**Effective Date:**	<Date>
PCN:	<PCN>	**Term Date:**	<Date>
Deductible:	Individual: <Ind Ded Amt > Family: < Family Ded Amt>	**Copay Assistance Applied to Deductible:**	<Yes/No>
Deductible Met YTD:	Individual: <Yes/No> Family: <Yes/No>	**Copay Assistance Applied to OOP:**	<Yes/No>
Product Copay Amount:	<$+Copay >	**Product Coinsurance Amount:**	<Co-Ins+%, Not Applicable>
SubQ 96372 Copay:	<$+Copay >	**Administration Coinsurance:**	<Co-Ins+%>
[PRODUCT] Coverage:	<Covered, Covered w/Approved PA, Covered w/Step Edit, Not Covered>	**PA Dept. Phone #:**	<XXX-XXX-XXXX>
PA Required:	<Yes/No>	**Approval #:**	<Approval #>
PA Start Date:	<mm/dd/yyyy>	**PA End Date:**	<mm/dd/yyyy>
Preferred Method of PA Submission:	<Phone, Fax, Email>	**PA Decision-Maker:**	<Plan/PBM>
Coding Requirements:	NDC: <Code> ICD Diagnosis Code: <Code> Other Diagnosis: <Code>	**Options for Procure:**	<Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>

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This section will only be included if the patient has secondary medical coverage. Once the primary insurance is applied, a secondary claim can be filed through this insurance plan.

Patient Name:	Patient DOB:	HUB ID#:
Prescriber Name:	Date of BI Completion:	

Secondary Medical Coverage Detail			
Payer Name:	<Payer Name>	**Plan Name:**	<Plan Name>
Payer Type:	<Medicare/Medicaid/Commercial>	**Plan Type:**	<HSA, PPO, HMO>
Policy Holder:	<Policy Holder>	**Member ID:**	<ID #>
Medical Plan Phone #:	<XXX-XXX-XXXX>	**Group #**	<Group #>
Effective Date:	<Date>	**Term Date:**	<Date>
Deductible:	Individual: <Ind Ded Amt > Family: < Family Ded Amt>	**Copay Assistance Applied to Deductible:**	<Yes/No>
Deductible Met YTD:	Individual: <Yes/No> Family: <Yes/No>	**Copay Assistance Applied to OOP:**	<Yes/No>
Product Copay Amount:	<$+Copay >	**Product Coinsurance Amount:**	<Co-Ins+%, Not Applicable>
SubQ 96372 Copay:	<$+Copay >	**Administration Coinsurance:**	<Co-Ins+%>
[PRODUCT] Coverage:	<Covered, Covered w/Approved PA, Covered w/Step Edit, Not Covered>	**PA Dept. Phone #:**	<PA #>
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Preferred Method of PA Submission:	<Phone, Fax, Email>	**PA Decision-Maker:**	<Plan/PBM>
PA Requirements:	<PA NOTES>		
Plan Limitations Cap Limit:	<Yes/No>	**Plan Limitations Cap Amount:**	$<XXX.XX>
Plan Limitations Cap Amount Frequency:	<Annually/Monthly/Quarterly/Semi-Annually/Daily/Other>	**Plan Limitations Quantity Limit:**	<Number>
Plan Limitations Quantity Limit Met to Date:	<Number>	**Coverage Restrictions:**	<Coverage Restrictions>
Coding Requirements:	NDC: <Code> ICD Diagnosis Code: <Code> Other Diagnosis: <Code>	**Options for Procure:**	<Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>

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