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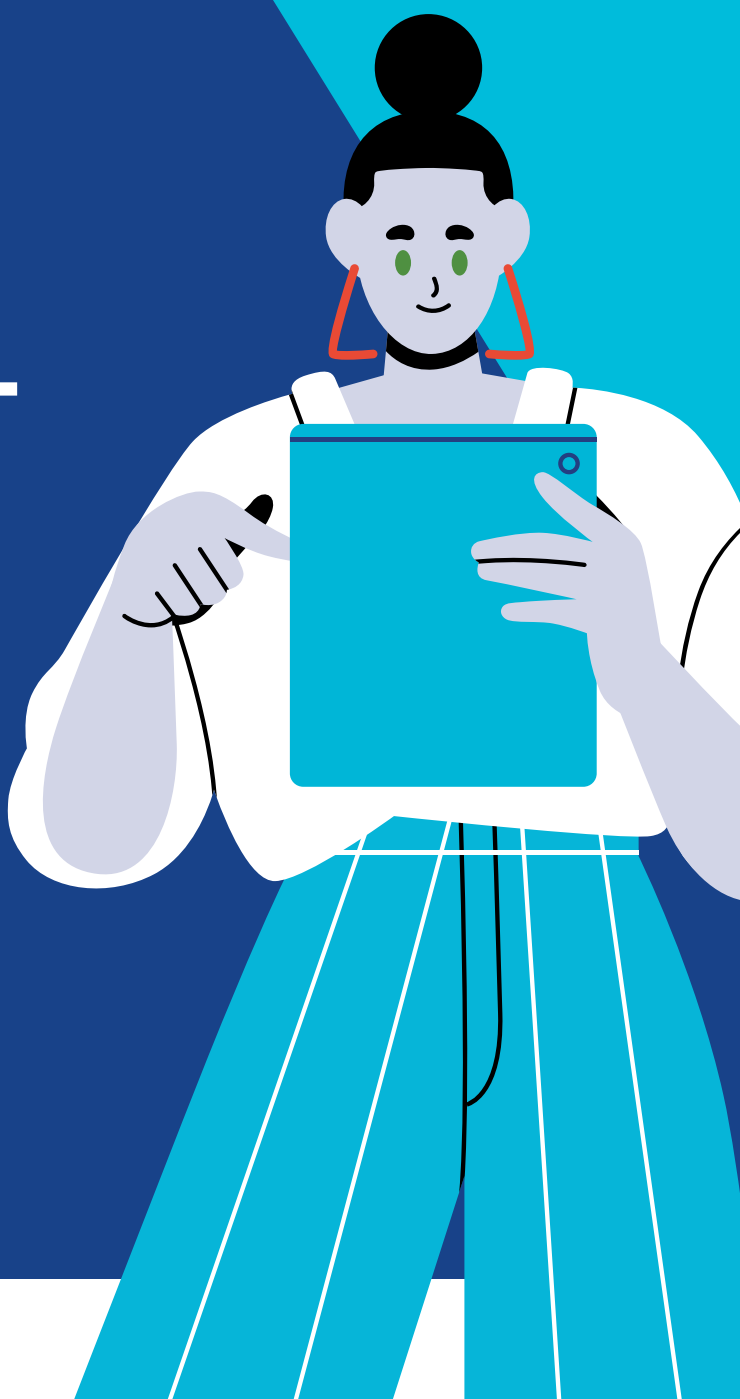
INSUPPORT® PATIENT ENROLLMENT FORM

USER GUIDE

Updated January 2024



NP-BAG-US-00976 EXPIRY September 2025

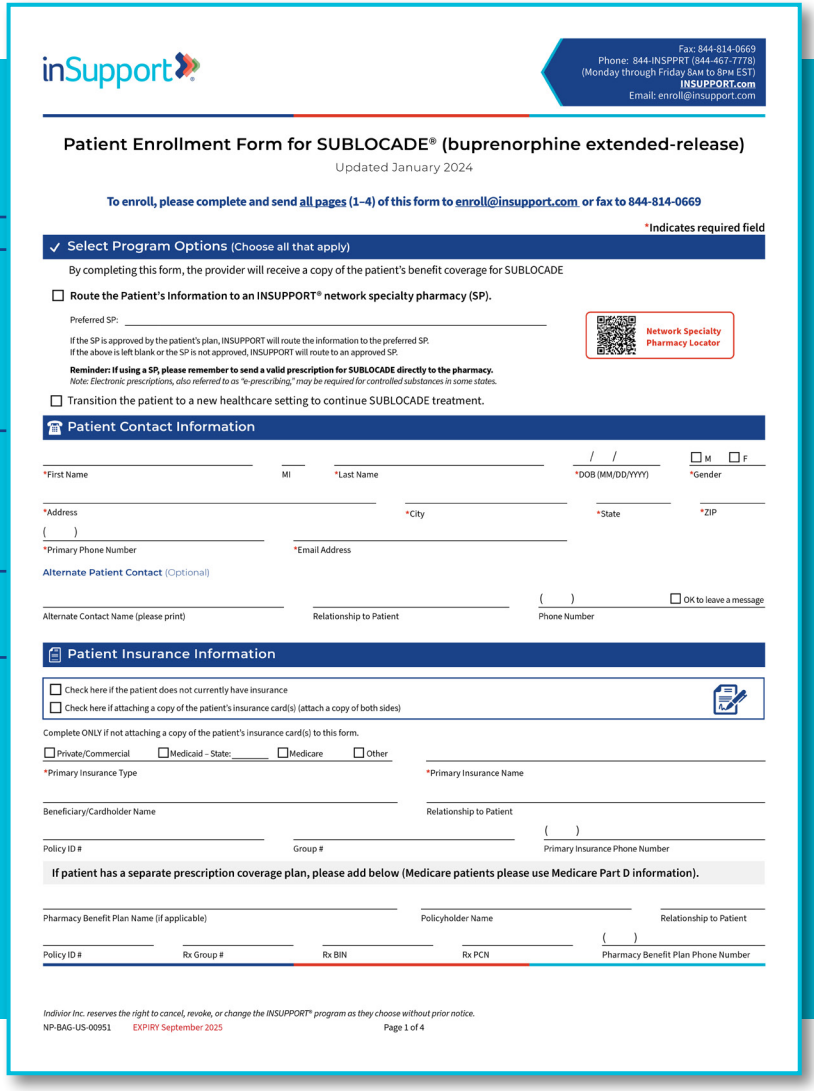
All required fields on this form are indicated with a red asterisk (*). Once all required information is completed on this form, please fax all pages (1–4) to INSUPPORT® at 844-814-0669, or submit online at **INSUPPORTportal.com**.

This information is required. For each program option, there is a description of the information provided by INSUPPORT. Please select all applicable options.

All patient contact information is required.

The patient may designate alternate contacts here to allow INSUPPORT to share information related to the patient's requested program options with the individuals named. This information is optional.

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: 844-814-0669
Phone: 844-INSPPRT (844-467-7778)
(Monday through Friday 8AM to 8PM EST)
INSUPPORT.com
Email: enroll@insupport.com

Patient Enrollment Form for SUBLOCADE® (buprenorphine extended-release)

Updated January 2024

To enroll, please complete and send all pages (1–4) of this form to enroll@insupport.com or fax to 844-814-0669

*Indicates required field

Select Program Options (Choose all that apply)

By completing this form, the provider will receive a copy of the patient's benefit coverage for SUBLOCADE

☐ **Route the Patient's Information to an INSUPPORT® network specialty pharmacy (SP).**

Preferred SP: _____

If the SP is approved by the patient's plan, INSUPPORT will route the information to the preferred SP.
If the above is left blank or the SP is not approved, INSUPPORT will route to an approved SP.

Network Specialty Pharmacy Locator

Reminder: If using a SP, please remember to send a valid prescription for SUBLOCADE directly to the pharmacy.
Note: Electronic prescriptions, also referred to as "e-prescribing," may be required for controlled substances in some states.

☐ Transition the patient to a new healthcare setting to continue SUBLOCADE treatment.

Patient Contact Information

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

*Address | *City | *State | *ZIP

( ) *Primary Phone Number | *Email Address

Alternate Patient Contact (Optional)

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

Patient Insurance Information

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

Complete ONLY if not attaching a copy of the patient's insurance card(s) to this form.

☐ 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

If patient has a separate prescription coverage plan, please add below (Medicare patients please use Medicare Part D information).

Pharmacy Benefit Plan Name (if applicable) | Policyholder Name | Relationship to Patient

Policy ID # | Rx Group # | Rx BIN | Rx PCN | ( ) Pharmacy Benefit Plan Phone Number

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

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Provider 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 Community Provider information should be provided in Step 6. Please complete the practice contact information to indicate a specific person for INSUPPORT® to contact regarding this case, if needed.

Treatment information must be completed by the treatment provider for the fulfillment of the benefit investigation process with the patient's insurance provider, where applicable. The information in this section is also necessary to validate the FDA-approved use of SUBLOCADE® (buprenorphine extended-release). For a list of ICD-10 codes that may be used for appropriate SUBLOCADE patients, please see the Billing and Coding Guide by using this QR code.

For patients enrolled in Transition of Care only, provide the new Community 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 SUBLOCADE is due after leaving your site of care.

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.

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Fax INSUPPORT®: 844-814-0669
*Indicates required field

Provider Information

*Provider First Name | *Provider Last Name | *Provider NPI #

☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Hospital ☐ Residential Treatment Facility

*Facility Type | Practice/Facility Name

*Practice Address | *City | *State | *ZIP

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

☐ Send all communications via email

Provider Email | *Provider Tax ID# | Practice NPI #

Treatment Information

*ICD-10 Diagnosis Code: _____ Last Injection Date: ___/___/___ (if known)

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

For a list of ICD-10 codes that may be used for appropriate SUBLOCADE® (buprenorphine extended-release) patients, please see the Billing and Coding Guide

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

☐ Check here if you would like INSUPPORT to schedule the patient's first appointment

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 | ___/___/___ *Next Injection Due Date (date should be after the discharge/release date)

Provider Attestation (Required)

By signing below, I certify the following:

1) The information inserted in this 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 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 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) 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 Practice 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 Provider Attestation.

*Provider Signature:_____ *Date:_____

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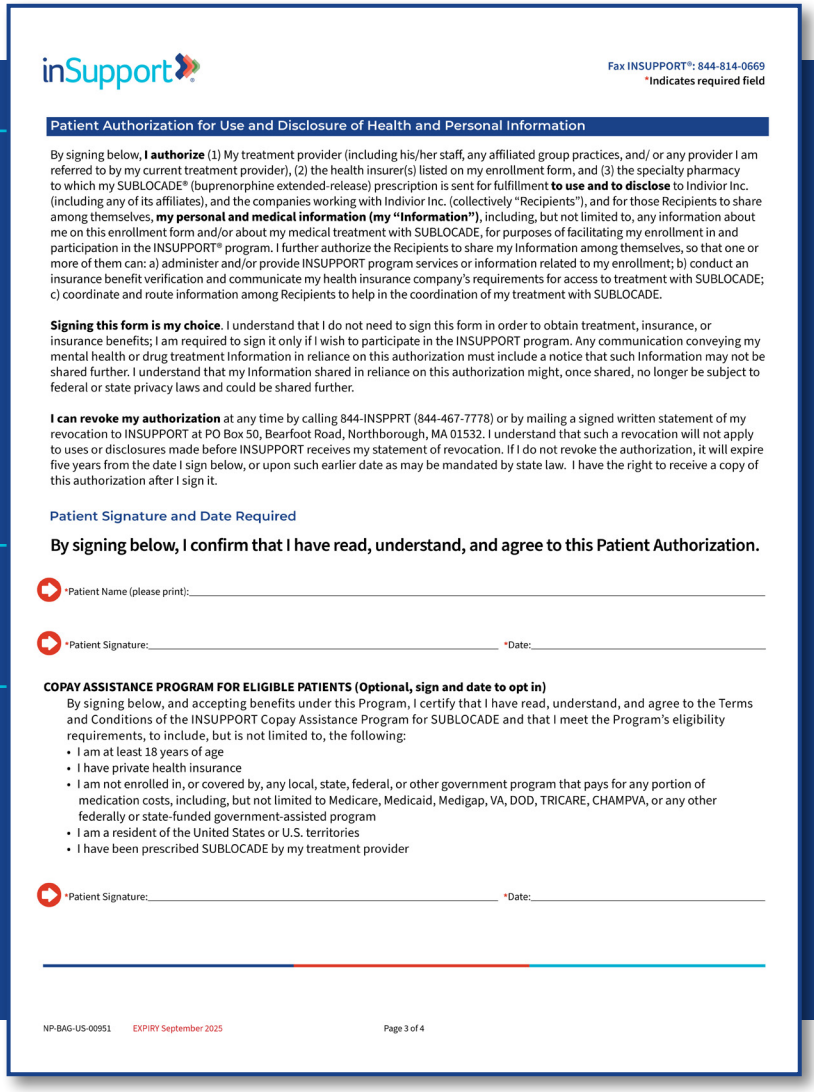
The patient should review this Patient Authorization prior to completing the authorization. The authorization includes, but is not limited to, details of why and to whom INSUPPORT® may use or disclose the patient's personal and medical information.

The patient's name, signature, and date are required to initiate any request from INSUPPORT. Any enrollment form received by INSUPPORT with an incomplete Patient Authorization will be returned to the enrolling treatment provider for completion by the patient or will require the patient to provide a completed stand-alone Patient Authorization Form to INSUPPORT. If your patient is not in the office, you may send a request to the patient to capture their authorization electronically at **INSUPPORTportal.com.**

To request additional assistance, the patient must opt in. This is optional. The patient must sign and date to opt into the INSUPPORT CoPay Assistance Program, if eligible.



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Fax INSUPPORT®: 844-814-0669
*Indicates required field

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:_____

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

*Patient Signature:_____ *Date:_____

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This page provides the Terms and Conditions necessary for participation in the INSUPPORT® Copay Assistance Program. If the patient is opting into the INSUPPORT Copay Assistance Program, the patient and treatment provider confirm that they have reviewed and agree to the Program's terms and the applicable certifications when signing the enrollment form.

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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.

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