

INSUPPORT® PATIENT AUTHORIZATION

TO COMPLETE THIS FORM:



1 Complete the Patient Contact Information Section on page 2



2 Review the Terms and Conditions and Patient Certification for the INSUPPORT® Copay Assistance Program for SUBLOCADE® (buprenorphine extended-release)



3 Read, understand, and complete the Patient Authorization on pages 3 and 4

- Complete any optional sections of the form on page 4, if desired
- **Complete all required fields on page 4: Provider Name and Phone (top of the page), your Printed Name, Signature and Date (bottom of page).**



4 Submit the completed Patient Authorization Form (all pages) to INSUPPORT via DocuSign or ask your HCP to submit via fax to 844-814-0669

IMPORTANT SAFETY INFORMATION

Because of the serious risk of potential harm or death from self-injecting SUBLOCADE into a vein (intravenously), it is only available through a restricted program called the SUBLOCADE REMS Program.

- **SUBLOCADE is not available in retail pharmacies.**
- **Your SUBLOCADE injection will only be given to you by a certified healthcare provider.**

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

Please see accompanying Full Prescribing Information, including **BOXED WARNING** and Medication Guide, or go to SUBLOCADE.com.

Patient Contact Information

*First Name	MI	*Last Name	/ /	*Gender	M	F
			*DOB (MM/DD/YYYY)			
*Address		*City	*State	*ZIP		
()		()				
*Primary Phone Number	Cell Phone Number	Email Address				

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 and less than 65 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.
- The INSUPPORT Copay Assistance Program is not insurance.

Program Enrollment:

- Patient's provider must request eligibility determination and enrollment for the Copay Assistance Program on behalf of the patient via the INSUPPORT Patient Enrollment Form or the INSUPPORT® Copay Assistance Portal located at www.insupportcopay.com.
- Enrollment forms that are modified or do not contain the information required for the requested services will not be accepted by INSUPPORT for evaluation of Program eligibility.
- Patient's signature and date on the Patient Authorization and Consent is required for INSUPPORT to enroll an eligible patient in the INSUPPORT Copay Assistance Program. The signed Patient Authorization and Consent is:
 - Valid for two years from the date of signature
 - Required to be provided each calendar year during re-enrollment in order for the patient to continue in the Program, assuming all other eligibility criteria continues to be met.
 - Applicable to only one practice and affiliated provider(s). Should the patient change to a provider belonging to a different practice, the patient's eligibility to receive benefits under the Copay Assistance Program will not be impacted, however the patient and the new provider must complete the required information on the Enrollment Form before the Program benefit for which the patient is eligible can be paid to such provider on the patient's behalf.
- The eligibility period for the Copay Assistance Program is based on calendar year (January thru December).
 - If the patient's initial enrollment into the INSUPPORT Copay Assistance Program is between October 1st and December 31st, the patient will not have to re-enroll in the program at the beginning of the subsequent calendar year. As a result, the patient's first enrollment period may be up to 15 months, and any subsequent enrollment periods will be one calendar year.
 - Eligible patients may receive benefits for valid claims submitted with a date of service that is up to 90 days prior to the initial enrollment date, and up to 30 days prior to the re-enrollment date.

Program Benefit and Conditions:

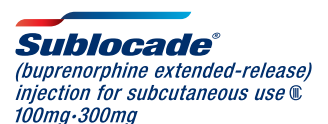
- Eligible patients may pay as little as \$5 per injection of SUBLOCADE throughout the eligibility period.
- Following the patient's initial enrollment in the Program, and each subsequent calendar year the patient remains on SUBLOCADE and continues to meet the Program eligibility criteria, the patient 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 \$1,659 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 \$12,918.
- 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 from 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 the 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 and provider agree not to seek reimbursement from any insurer or payor for any or all of the benefit received by the patient through the Copay Assistance Program.
- 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.

Patient Certification for the INSUPPORT® Copay Assistance Program (Private or Commercial insurance only)

By 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 and that I meet the Program's eligibility requirements, to include the following:

- 1) I have private health insurance which covers some portion of my prescribed medication; 2) I will not seek reimbursement for cost of my prescribed medication (in full or in part) from any state, federal, or government funded healthcare programs such as Medicaid, Medicare, TRICARE, Department of Defense, or Veterans Administration, etc.; 3) I will not seek reimbursement for the cost of my prescribed medication (in full or in part) from any third-party payers, including a flexible spending or healthcare savings account; 4) I will notify INSUPPORT immediately if I change providers, if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer.

For **BOXED WARNING** see first page. Please see accompanying Full Prescribing Information, including **BOXED WARNING** and Medication Guide, or go to SUBLOCADE.com.



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 prescription is sent for fulfillment **to use and to disclose** to Indivior Inc. (including any of its affiliates), INSUPPORT, McKesson Corporation and any of its affiliates including RxCrossroads by McKesson, SourceHOV L.L.C., NDC Health Corporation d/b/a/ RelayHealth, Capgemini America, Inc., Symphony Health Solutions, Corporation (including its affiliate Source Healthcare Analytics, L.L.C.), AmerisourceBergen Corporation (including its affiliate Xcenda L.L.C.), and my Alternate Patient Contact(s) (if named) (collectively “Recipients”), and for those Recipients to share among themselves, **my personal and medical information (my “Information”)**, including any information about me on this enrollment form and/or about my medical treatment with SUBLOCADE. This information may be shared to allow the Recipients to: a) administer the INSUPPORT program; b) comply with safety regulations; c) conduct an insurance benefit verification and communicate my health insurance company’s requirements for access to treatment with SUBLOCADE; d) coordinate and route information among Recipients to help in the coordination of my treatment with SUBLOCADE; e) provide me with educational information and materials related to my enrolled services; f) invite me to participate in optional surveys about my treatment, and/or; g) provide me with program information about, determine if I am eligible for, and help with my enrollment and continued participation in, the INSUPPORT® Copay Assistance Program for SUBLOCADE. I understand that my specialty pharmacy may receive payment from Indivior Inc. in exchange for providing my Information per this authorization.

I understand that **my default communication method** to receive information from INSUPPORT is **via US mail**. At any time, I can change my communication method, and any other information on my enrollment form, by calling 844-INSPPRT (844-467-7778). **Signing this form is my choice**. If I do not sign this form, it will not affect my ability to obtain treatment, insurance, or insurance benefits. If I do not sign the form, this will only limit my ability to participate in the INSUPPORT program. This authorization does not permit the recipient of my mental health and drug treatment Information to further share the Information without my permission unless allowed under state and federal law. Any communication containing my mental health or drug treatment Information in reliance on this authorization must include a notice that such Information may not be shared further. Other Information shared as a result of this authorization may, once shared, no longer be subject to federal law and could be shared further. This authorization will expire two (2) years from the date I sign the form below, or upon such earlier date as may be mandated by state law. **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 29297, Phoenix, AZ 85038. I understand that such a revocation will not apply to uses or disclosures made before INSUPPORT receives my statement of revocation. I have the right to receive a copy of this authorization after I sign it.

Patient Authorization for Use and Disclosure of Health and Personal Information (Cont.)**Additional Options - check the box to opt-in**

Note: INSUPPORT will exercise selected opt-ins only if applicable for the program option(s) requested on this form.

INFORM ME: I authorize McKesson Corporation and its affiliates to disclose my Information to Klick Health so it may send me educational materials, via email or US mail, related to my treatment with SUBLOCADE, or other related Indivior products and services.

MAIL ME: I authorize INSUPPORT to use my Information to provide me a copy of my benefit coverage information for SUBLOCADE.

CALL ME: I authorize INSUPPORT to use my Information so I may receive a phone call or voicemail, at the phone number provided below, for the purpose of INSUPPORT to review my benefit coverage information for SUBLOCADE with me.

Phone Number for Calls: () _____

Best Time to Call: Morning Afternoon Evening

TEXT ME: I authorize INSUPPORT to use my Information to send me text reminders, at the mobile phone number provided below, for my upcoming next injection due date and/or appointment date with my new provider, related to my transition of care, based on the information INSUPPORT has on file. I acknowledge that standard text message rates apply.

Mobile Phone Number for Text Messages: () _____

Alternate Patient Contact(s) (Optional)

Alternate Contact Name (please print) Relationship to Patient ()
Phone Number

Alternate Contact Name (please print) Relationship to Patient ()
Phone Number

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

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