Fax: 844-814-0669
Phone: 844-INSPPRT (844-467-7778)
INSUPPORT.com
Email: enroll@insupport.com

PATIENT ENROLLMENT FORM FOR SUBLOCADE® (buprenorphine extended-release)

To enroll in INSUPPORT®, and receive a copy of the patient's benefit coverage for SUBLOCADE, please complete all pages (1-5) of this form and email all pages to enroll@insupport.com or fax all pages to 844-814-0669

Acquisition Pathway and Benefit Verification

Select the preferred acquisition pathway below. The information will be used during the benefits verification process.

☐ Specialty Pharmacy

☐ Route the Patient's Information to an Insupport Network Specialty Pharmacy

Preferred Specialty Pharmacy: _____

If the specialty pharmacy is in network by the patient's plan, INSUPPORT will route the information to the preferred specialty pharmacy.

If the preferred specialty pharmacy is left blank, or the specialty pharmacy is not in network, INSUPPORT will route to an in-network specialty pharmacy.

☐ Buy and Bill

INSUPPORT can conduct a benefit investigation to determine if the patient's health plan only allows buy and bill access for SUBLOCADE.

INSUPPORT can provide contact information for network specialty distributors.

Network Specialty Pharmacy Locator
insupport.com/specialty-product/specialty-pharmacy-locator

SUBLOCADE Network Specialty Distributors List
insupport.com/resources

Additional Program Options and Related Instructions

INSUPPORT Copay Assistance Program

INSUPPORT offers a Copay Assistance Program to help eligible patients with the out-of-pocket costs for SUBLOCADE. Eligible patients may pay as little as $0 per injection of SUBLOCADE. **To enroll the patient in the Copay Assistance Program, Sections 1-4 and Sections 7-8 must be completed**.

Community Reentry Program Enrollment

Provides up to 2 months of product at no cost to enrolled patients, who are transitioning from a criminal justice facility, while they obtain insurance coverage. For full terms and conditions, please see page 3. **To enroll the patient in the Community Reentry Program, Sections 1-5 and Sections 7-8 must be completed**

Transition of Care

For patients departing their current site of care and continuing treatment with a new provider: for example, patients involved in the criminal justice system or receiving treatment at a residential treatment center. **To enroll the patient in Transition of Care support, Sections 1-4 and Sections 6-8 must be completed**

SECTION 1 Patient Contact Information

*Indicates required field

_____ *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

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

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*Indicates required field

SECTION 2 Patient Insurance Information

☐ Check here if submitting a copy of the patient's medical and pharmacy insurance card(s) with the enrollment form (attach a copy of both sides)

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

☐ Private/Commercial ☐ Medicaid – State: _____ ☐ Medicare ☐ Other ☐ Uninsured

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

SECTION 3 Provider/Coordinator* Information

*Provider/Coordinator First Name

*Provider/Coordinator Last Name

†Provider NPI #

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

*Facility Type

Criminal Justice System (CJS)

*Practice/Facility Name

*Practice/Facility Address

*City

*State

*ZIP

( ) *Practice/Facility Phone Number

( ) *Practice/Facility Fax Number

Practice/Facility Contact First and Last Name

( ) Practice/Facility Contact Phone Number

Provider/Coordinator Email

☐ Send all communications via email

†Provider Tax ID#

Practice NPI #

*Coordinator information is required for patients who are currently receiving treatment through the CJS and who are enrolling in transition of care.
†: This field is required for providers.

SECTION 4 Treatment Information

*ICD-10 Diagnosis Code: _____ Next Injection Due Date: ____/____/_____

*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

insupport.com/billing

☐ Check here to verify payer coverage for a second SUBLOCADE dose between day 8 and day 27. If the second dose will occur past day 27, do not check the box

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

Days supply written on first fill: _____

(First fill days supply should reflect that the accelerated second dose of 300-mg SUBLOCADE injection can be given as early as day 8 and up to 1 month after the first dose)

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*Indicates required field

SECTION 5 COMMUNITY REENTRY PROGRAM ENROLLMENT FORM

Community Reentry Program Patient Eligibility Requirements

The INSUPPORT® Community Reentry Program's eligibility requirements include, but are not limited to, the following:

- The Community Reentry Program is available to patients for "on-label" use.
- Patient has applied for insurance coverage and is pending payer enrollment decision.
- Patient is a resident of the United States or U.S. territories.
- Patient is currently taking or was previously prescribed SUBLOCADE® (buprenorphine extended-release) by a treatment provider.
- Patient has been given a certain release date or has been recently released from the criminal justice system.

Community Reentry Program Next Steps

1. Fax prescription to AllCare Plus Pharmacy at 844-470-2806, or

2. ePrescribe through the eRx platform to AllCare Plus Pharmacy, **NPI 190216796**

Product for patients enrolled in the Community Reentry Program will be shipped and confirmed from AllCare Plus Pharmacy to the healthcare provider. **Provider signature required on page 4 to enroll patient in the Community Reentry Program.**

Community Reentry Program Terms and Conditions

The Community Reentry Program provides transition of care for an eligible patient prescribed SUBLOCADE who is transitioning from a criminal justice facility to the community without access to health insurance upon release. The Community Reentry Program provides up to 2 months of product at no cost to enrolled patients while they obtain insurance coverage for SUBLOCADE. Patients must be currently receiving SUBLOCADE therapy and experiencing a gap in insurance coverage. Patients who have not yet received their first dose of SUBLOCADE are not eligible. Product provided through the Community Reentry Program at no charge is only available through a Community Reentry Program contracted pharmacy (INSUPPORT Network specialty pharmacy). Eligibility will be determined based on the Community Reentry Program eligibility requirements. Indivior reserves the right to change or end the Community Reentry Program at any time, and other terms and conditions may apply.

SECTION 6 Transition of Care Information

☐ Check here if patient is transitioning from the criminal justice system

Locate a Community Provider

To find a treatment provider who prescribes 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.com/findtreatment

If the patient does not need assistance locating a community provider, please provide their community provider information below. INSUPPORT will route patient information to the below community provider.

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

*Facility Type _____ Facility Name _____

*Provider Name _____ *Provider NPI# _____ *Provider Address _____ *City _____ *State _____ *ZIP _____

( ) _____ _____ / / _____

*Provider Phone Number *Provider Fax Number *Next Injection Due Date

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*Indicates required field

SECTION 7 Provider/Coordinator Attestation

Provider and/or Coordinator Signature Required*
By signing below, I certify the following:

1) The information inserted in this Enrollment Form has been provided exclusively by me (the provider/coordinator named in this Form) or my office or my facility ("my Practice or Facility") 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 or Facility 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/Facility 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/Coordinator Attestation.

Provider or Criminal Justice System Coordinator Signature:_____

Date:_____

Provider signature required if enrolling patient in the Community Reentry Program. See Section 5 for more information about the Community Reentry Program.
By signing below, I certify the following:

I (the prescriber) understand and agree that: I certify that the patient and physician information obtained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed SUBLOCADE® (buprenorphine extended-release) based on my professional judgment of medical necessity. Any medications supplied by Indivior as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement. I have received the necessary legal authorization from the patient to transmit the patient's personal health information, for the purposes provided on this form, to Indivior or its vendor affiliates. INSUPPORT may contact me for additional information relating to the Program, including but not limited to via email, fax, telephone, and text. I understand that the Community Reentry Program is designed to support patients who are experiencing a delay in obtaining insurance coverage for SUBLOCADE upon transition from the Criminal Justice System. I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I understand that neither I nor the patient may seek reimbursement for free product received under the program.

By signing below, I confirm that I have read, understand, and agree to this Provider Authorization.

*Provider Signature:_____ *Date:_____

*Either the Provider or the Coordinator must sign the Provider/Coordinator Attestation for this form to be complete. Coordinator signature is required for patients who are currently receiving treatment through the CJS and who are enrolling in Transition of Care.

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*Indicates required field

SECTION 8 Patient Authorization for Use and Disclosure of Health and Personal Information

By signing below, **I authorize** (1) My treatment provider (including 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; d) provide me with educational or support services by mail, email, and/or telephone, which may include sending me product and/or treatment information; e) invite me to participate in optional surveys about my treatment, and/or; f) 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 and the Community Reentry Program. I understand that my specialty pharmacy may receive payment from Indivior Inc. in exchange for providing my Information per this authorization.

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 (5) 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. I understand that I may refuse to sign this authorization and that refusing to sign this authorization will not change the way my physician, health insurance, and pharmacy providers treat me.

☐ **COPAY ASSISTANCE PROGRAM FOR ELIGIBLE PATIENTS. Patient must check the box to opt in to the Copay Assistance Program.**

By checking the box, 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 and Date Required

All patients must complete and sign the Patient Authorization for Use and Disclosure of Health and Personal Information

By signing below, I confirm that I have read, understand, and agree to this Patient Authorization.

*Patient Name (please print):_____

*Patient Signature:_____ *Date:_____

For INSUPPORT Copay Assistance Program full terms and conditions, visit https://www.insupport.com/pdf/copay-assistance-terms-and-conditions.pdf

For additional information, reach out to INSUPPORT.

Call: 844-INSPPRT (844-467-7778)
Email: enroll@insupport.com

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