PO Box 29297 | Phoenix, AZ 85039
Phone: 844-INSPPRT (844-467-7778)
Fax: 844-814-0669
www.insupport.com

PATIENT ENROLLMENT FORM

TO ENROLL WITH INSUPPORT™

1. Check the box for the requested service below and complete the enrollment form as indicated in the instructions.
2. Check that all required signatures have been obtained.
3. Fax the completed form to INSUPPORT at 844-814-0669.

If the patient has completed the required portions of the Enrollment Form, enrollment can be completed by the treatment provider via the INSUPPORT Provider Portal at www.providerportal.insupport.com.

STEP 1 Requested INSUPPORT Services

☐ **Hub Services – Benefit Investigation and Copay Assistance or Alternate Funding Research, as applicable**

To initiate a Benefit Investigation of the patient's insurance coverage for SUBLOCADE™ (buprenorphine extended-release), and/or obtain information on any associated prior authorizations, appeals, and financial assistance – including, if applicable, determine eligibility and enroll patient in the Copay Assistance Program for SUBLOCADE, or provide alternate sources of funding information, and/or route patient information to a specialty pharmacy, the **patient and provider** must review and complete steps 1–8.

☐ **Apply for the Copay Assistance Program for SUBLOCADE**

Copay assistance is available for eligible privately insured patients to assist with the out-of-pocket cost of SUBLOCADE. Not all patients are eligible. Terms and Conditions apply. To apply, the **patient and provider** must review and complete steps 1–3, and steps 5–8.

☐ **Copay Assistance Re-enrollment or Update to Copay Member Information (For existing patients only)**

Copay Member ID: _____

To re-enroll in the INSUPPORT Copay Assistance Program, or to update patient contact information, insurance information, or treatment provider, the **patient** must complete step 1 as well as the steps below:

- If there is a change in the patient's contact or insurance information, the **patient** must provide the new information and check the applicable "Update" box in step 2 and/or 3.
- **If the patient's treatment provider has changed at any time,** the **patient and provider** must review and complete steps 5–8 (Note steps 5–7 are required to be completed and signed by the provider).
- If there has been no change in the patient's contact information, insurance information, or treatment provider, the **patient** must complete step 8 to re-enroll in the INSUPPORT Copay Assistance Program.

☐ **Denied Claim Research**

To initiate a review and research of a patient's denied claim, the Explanation of Benefits and copy of the denial correspondence from the patient's health insurer are required. The **patient and provider** must also review and complete steps 1–3, and steps 5–8.

☐ **Alternate Funding Research**

To initiate research into alternate sources of funding for an uninsured or underinsured patient, the **patient and provider** must review and complete steps 1–8.

WARNING: RISK OF SERIOUS HARM OR DEATH WITH INTRAVENOUS ADMINISTRATION; SUBLOCADE RISK EVALUATION AND MITIGATION STRATEGY

- **Serious harm or death could result if administered intravenously. SUBLOCADE forms a solid mass upon contact with body fluids and may cause occlusion, local tissue damage, and thrombo-embolic events, including life threatening pulmonary emboli, if administered intravenously.**
- **Because of the risk of serious harm or death that could result from intravenous self-administration, SUBLOCADE is only available through a restricted program called the SUBLOCADE REMS Program. Healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified in this program and comply with the REMS requirements.**

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

See accompanying full Prescribing Information, including **BOXED WARNING** or go to sublocade.com.

Sublocade™ (buprenorphine extended-release) injection for subcutaneous use Ⓒ 100mg·300mg

inSupport™

Fax INSUPPORT: 844-814-0669

STEP 2 Patient Contact Information

☐ Update

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

Address | City | State | ZIP

( ) Primary Phone Number | ( ) Cell Phone Number | Email Address

STEP 3 Patient Insurance Information

☐ Update

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Patient is insured ☐ Y ☐ N

Primary Insurance Type ☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Other

Secondary Insurance Type ☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Other

Primary Insurance Name

Beneficiary/Cardholder Name | Relationship to Patient

Policy ID # | Group # | ( ) Primary Insurance Phone Number

Secondary Insurance Name (if applicable)

Beneficiary/Cardholder Name | Relationship to Patient

Policy ID # | Group # | ( ) Phone

If patient has a separate prescription coverage plan, please list 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

Secondary Pharmacy Benefit Plan Name (if applicable)

Policyholder Name | Relationship to Patient

Policy ID # | Rx Group #

Rx BIN | Rx PCN

( ) Pharmacy Benefit Plan Phone Number

STEP 4 Patient Financial Information (Required for Alternate Funding Research)

If additional proof of income is required to determine patient eligibility, INSUPPORT will contact the patient directly.

Number of individuals (including patient) who live in household _____

Gross Monthly Household Income _____

(Please include: before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

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STEP 5 Provider Information

☐ Update

First Name | Last Name

NPI # | State License # | DEA #

Facility/Practice Name | Practice NPI # | Tax ID #

Practice Address | City | State | ZIP

( ) Practice Phone Number | ( ) Practice Fax Number

Practice Contact First and Last Name | ( ) Practice Contact Phone Number | Practice Contact Email Address

Preferred Product Acquisition:

☐ Specialty Distributor—Buy-and-Bill ☐ Specialty Pharmacy Preferred Specialty Pharmacy:_____

(Used if specialty pharmacy is not payer-mandated)

STEP 6 Treatment Information (To be completed by the provider only)

ICD-10 Diagnosis Code: _____ Prescribed Dose: ☐ SUBLOCADE™ 100 mg ☐ SUBLOCADE™ 300 mg

Scheduled Injection Date: _____ (if known)

Provider Certification: The INSUPPORT Copay Assistance Program

By signing below, I certify that:

- I have prescribed the Program Product to the patient indicated on the request in the exercise of my independent medical judgment for its FDA-approved indication.
- I have read the Terms and Conditions of the INSUPPORT Copay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions.
- I/my office will not take into account the fact that the patient may receive a benefit from the Copay Assistance Program when determining the amount of any charge(s) to the patient.
- I certify that I/my office will not charge the patient any fee to complete this form and I/my office will not advertise or otherwise use the Copay Assistance Program as means of promoting my services or the Program Product.
- The claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.
- I am/my office is responsible for reporting receipt of Copay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Copay Assistance Program, as may be required.
- I/my office will not seek reimbursement for any part of the benefit received by the patient through the Copay Assistance Program.
- The patient's benefit received under the Copay Assistance Program will be paid directly to me/my office by the Copay Assistance Program on behalf of my patient. I/my office will apply any amounts received from the Copay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my office already received payment from the patient for the patient's share of the cost of the Program Product for which the patient receives a benefit through the Copay Assistance Program, I/my office will refund the amounts received back to the patient.
- I may be asked to sign a new Provider Certification if the Terms and Conditions of the Copay Assistance Program for the Program Product change.

STEP 7 Provider Authorization

By signing below, I certify the following:

- This request for services has been prepared exclusively by the provider or provider's office identified in this request ("my Practice").
- The prescribed medication is medically appropriate for the patient identified based on my best professional judgment and that my practice will be supervising the patient's treatment.
- The information provided in this request is accurate to the best of my knowledge.
- My Practice has obtained written authorization from the patient identified in this request to disclose the patient's personal health information and any other information on this enrollment form as may be required by INSUPPORT to provide the services requested, as 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 Confidentiality of Substance Use Disorder Patient Records Regulation (codified at 42 C.F.R. Part 2), as amended from time to time.
- That (a) any service provided through INSUPPORT on behalf of any patient is not made in exchange for any expressed or implied agreement or understanding that I would recommend, prescribe, or use INSUPPORT or any other product or service for anyone, and that (b) my decision to prescribe the products set forth on this page and request of INSUPPORT services for my patient was based solely on my determination of medical necessity as set forth herein.
- That INSUPPORT may contact me for additional information relating to the requested services, including but not limited to via email, fax and telephone.
- That completing this enrollment form does not ensure that the patient will obtain insurance coverage or reimbursement for the prescribed medication, and that any service provided through INSUPPORT is provided for information purposes only and represent no statement, promise or guarantee by INSUPPORT or Indivior Inc. I agree that in no event shall Indivior be liable for any damages resulting from or relating to requested or provided services from INSUPPORT.
- I may be invited to participate in optional surveys regarding education and patient treatment.
- That I understand that Indivior Inc. reserves the right, at any time and without notice, to rescind, revoke, or amend any INSUPPORT services.

By signing below, I confirm that I have read, understand and agree to the Provider Certification and Terms and Conditions for the INSUPPORT Copay Assistance Program, as applicable, and the Provider Authorization.

X

Provider Signature | Date

For **BOXED WARNING** refer to front page; See accompanying full Prescribing Information, including **BOXED WARNING** or go to sublocade.com.

Sublocade™ (buprenorphine extended-release) injection for subcutaneous use Ⓒ 100mg·300mg

inSupport™

Fax INSUPPORT: 844-814-0669

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.

Program Enrollment:

- Patient's provider must submit a completed INSUPPORT Patient Enrollment Form requesting eligibility determination and enrollment for the Copay Assistance Program on behalf of the patient.
- 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 determine eligibility and enroll the 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.

Program Benefit and Conditions:

- The INSUPPORT Copay Assistance Program is not insurance.
- Patient will have an out-of-pocket minimum of $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 $1580 for SUBLOCADE.
  - Following the first two injections of SUBLOCADE in the same calendar year, the patient will receive a maximum copay assistance amount of up to $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.
- 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 and provider agree not to seek reimbursement for any or all of the benefit received by the patient through the Copay Assistance Program.
- The Copay Assistance Program benefit cannot be combined with any other Copay Assistance Program, free trial, discount, prescription savings card, or other offer.
- 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 signing this enrollment form, 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:

- I have private health insurance which covers some portion of my prescribed medication.
- 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.
- 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.
- 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, if I become entitled to, or enroll in a government health insurance program/payer.

For **BOXED WARNING** refer to front page; See accompanying full Prescribing Information, including **BOXED WARNING** or go to sublocade.com.

Sublocade™
(buprenorphine extended-release)
injection for subcutaneous use Ⓒ
100mg·300mg

inSupport™ Patient Name: _____ Provider Name: _____ Case ID: _____

Fax INSUPPORT: 844-814-0669

STEP 8 Patient Authorization and Consent for Use and Disclosure of Health and Personal Information

By signing below,

- **I authorize** 1. my treatment provider (including his/her staff and any affiliated group practices), 2. the health insurer(s) listed on my enrollment form, and 3. the specialty pharmacy that dispenses SUBLOCADE to me **to use and disclose** to Indivior Inc. (including any of its affiliates), McKesson Specialty Arizona Inc., SourceHOV L.L.C., Liquid Hub, Inc., Xcenda L.L.C., and my Authorized Patient Representative (if named) (collectively "Recipients"), and for those Recipients to share among themselves, **my personal and medical information**. This includes any information on my enrollment form, and about my medical treatment with SUBLOCADE (taken together, "Information"). This Information can be shared **for the specific purposes**, and as needed, to allow INSUPPORT to provide the services that I have signed up for, or to comply with safety regulations. The purposes may include one or more of the following:
  a) to conduct insurance benefit verification and communicate my health insurance company's requirements for access to treatment with SUBLOCADE;
  b) to coordinate services and route information between Recipients to help in the coordination of my treatment with SUBLOCADE;
  c) to provide me with educational information and materials related to my enrolled services;
  d) to invite me to participate in optional surveys about my treatment, and/or;
  e) to 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. INSUPPORT can also provide information on other programs or sources of funding to help me with the costs of my medication.
- 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). I can also update information on the INSUPPORT Patient Portal at www.myportal.insupport.com.
  - **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 receive the INSUPPORT services requested.
  - 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 or federal law. Any such information shared as a result of 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.
  - **I can revoke my authorization** at any time by calling at 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 once I let INSUPPORT know I revoke this authorization, there will be no further use or disclosure of my information, except to the extent that action has already been taken based on this authorization.
  - I have the right to receive a copy of this authorization after I sign it.
  - my specialty pharmacy may receive payment from Indivior Inc. in exchange for providing my Information per this authorization.

Additional Services – check the box to opt-in (Optional)

❑ ***Patient Benefit Summary Call*** *(Optional) – Only applicable if Benefit Investigation is requested*

I authorize INSUPPORT to contact me, or leave me a voicemail, at the number provided below specifically for the purposes of reviewing my benefit coverage information for my prescribed treatment, discussing the services for which I have enrolled and the associated process to receive my prescribed treatment, and establishing preferences for any further communication with INSUPPORT regarding my enrolled services. I understand that INSUPPORT does not and cannot provide medical advice.

Preferred Phone Number: (_____) _____ *Best Day to Call:* ☐ *M* ☐ *T* ☐ *W* ☐ *TH* ☐ *F* *Best Time to Call:* ☐ *Morning* ☐ *Afternoon* ☐ *Evening*

❑ ***Marketing Communications*** *(Optional)*

I authorize McKesson Specialty Health to disclose my personal information to Klick Health specifically to send me educational and marketing materials, via email or direct mail, related to my treatment with SUBLOCADE, and/or other related Indivior products and services.

❑ ***Scientific Research Opportunity*** *(Optional)*

I authorize McKesson Specialty Health to disclose my contact information to RTI International specifically to evaluate my interest in participating in a future research opportunity related to my treatment with SUBLOCADE.

Authorized Representative (Optional)

I grant permission for INSUPPORT to contact the Authorized Representative listed below to discuss any information provided within this enrollment or consent form, to discuss my treatment with SUBLOCADE, and communicate my ongoing preferences and need for INSUPPORT services. I understand that Indivior is not liable for any actions taken in response to direction provided by my Authorized Representative.

Authorized Representative/Guardian Name (please print)	Relationship to Patient	Phone Number ( )

Patient Signature

By signing below, I confirm that I have read, understand and agree to the Patient Authorization and Consent, and the Patient Certification for the INSUPPORT Copay Assistance Program, as applicable, based on the services requested on my enrollment form. By signing, I also certify that all information that I have provided in this application is complete and accurate.

X _____

Patient Signature Date

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