inSupport®

INSUPPORT® Final Benefit Summary

User Guide

NP-BAG-US-00425 EXPIRY March 2022

A benefit investigation allows the healthcare professional to understand a patient's insurance coverage for the prescribed medication before it is acquired or administered.

The information in the Coverage Detail section(s) is populated by INSUPPORT with information collected from the patient's insurance provider.

If the patient has health insurance or 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 Prescription Routing Information 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.

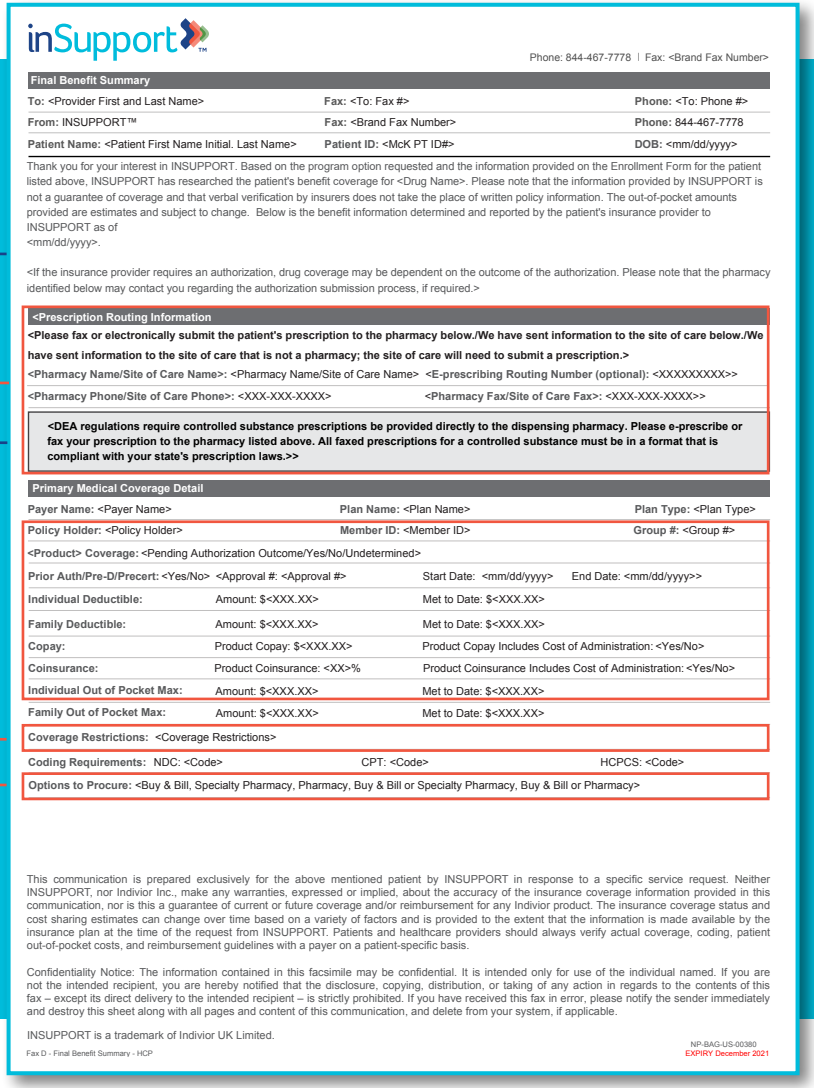
The HCP should promptly send the patient's prescription to the Specialty Pharmacy listed here in order to help reduce delays.

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 the medication.

It is essential that all HCPs follow Drug Enforcement Administration (DEA) regulations when prescribing controlled substances.

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.

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



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Phone: 844-467-7778 | Fax: <Brand Fax Number>

Final Benefit Summary

To: <Provider First and Last Name>	**Fax:** <To: Fax #>	**Phone:** <To: Phone #>
From: INSUPPORT™	**Fax:** <Brand Fax Number>	**Phone:** 844-467-7778
Patient Name: <Patient First Name Initial. Last Name>	**Patient ID:** <McK PT ID#>	**DOB:** <mm/dd/yyyy>

Thank you for your interest in INSUPPORT. Based on the program option requested and the information provided on the Enrollment Form for the patient listed above, INSUPPORT has researched the patient's benefit coverage for <Drug Name>. Please note that the information provided by INSUPPORT is not a guarantee of coverage and that verbal verification by insurers does not take the place of written policy information. The out-of-pocket amounts provided are estimates and subject to change. Below is the benefit information determined and reported by the patient's insurance provider to INSUPPORT as of <mm/dd/yyyy>.

<If the insurance provider requires an authorization, drug coverage may be dependent on the outcome of the authorization. Please note that the pharmacy identified below may contact you regarding the authorization submission process, if required.>

<Prescription Routing Information

<Please fax or electronically submit the patient's prescription to the pharmacy below./We have sent information to the site of care below./We have sent information to the site of care that is not a pharmacy; the site of care will need to submit a prescription.>

<Pharmacy Name/Site of Care Name>: <Pharmacy Name/Site of Care Name> **<E-prescribing Routing Number (optional):** <XXXXXXXXX>>

<Pharmacy Phone/Site of Care Phone>: <XXX-XXX-XXXX> **<Pharmacy Fax/Site of Care Fax>:** <XXX-XXX-XXXX>>

<DEA regulations require controlled substance prescriptions be provided directly to the dispensing pharmacy. Please e-prescribe or fax your prescription to the pharmacy listed above. All faxed prescriptions for a controlled substance must be in a format that is compliant with your state's prescription laws.>>

Primary Medical Coverage Detail

Payer Name: <Payer Name>	**Plan Name:** <Plan Name>		**Plan Type:** <Plan Type>
Policy Holder: <Policy Holder>	**Member ID:** <Member ID>		**Group #:** <Group #>
<Product> Coverage: <Pending Authorization Outcome/Yes/No/Undetermined>			
Prior Auth/Pre-D/Precert: <Yes/No> <Approval #: <Approval #>		Start Date: <mm/dd/yyyy>	End Date: <mm/dd/yyyy>>
Individual Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Copay:	Product Copay: $<XXX.XX>	Product Copay Includes Cost of Administration: <Yes/No>	
Coinsurance:	Product Coinsurance: <XX>%	Product Coinsurance Includes Cost of Administration: <Yes/No>	
Individual Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Coverage Restrictions: <Coverage Restrictions>			
Coding Requirements: NDC: <Code>	CPT: <Code>	HCPCS: <Code>	
Options to Procure: <Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>			

This communication is prepared exclusively for the above mentioned patient by INSUPPORT in response to a specific service request. Neither INSUPPORT, nor Indivior Inc., make any warranties, expressed or implied, about the accuracy of the insurance coverage information provided in this communication, nor is this a guarantee of current or future coverage and/or reimbursement for any Indivior product. The insurance coverage status and cost sharing estimates can change over time based on a variety of factors and is provided to the extent that the information is made available by the insurance plan at the time of the request from INSUPPORT. Patients and healthcare providers should always verify actual coverage, coding, patient out-of-pocket costs, and reimbursement guidelines with a payer on a patient-specific basis.

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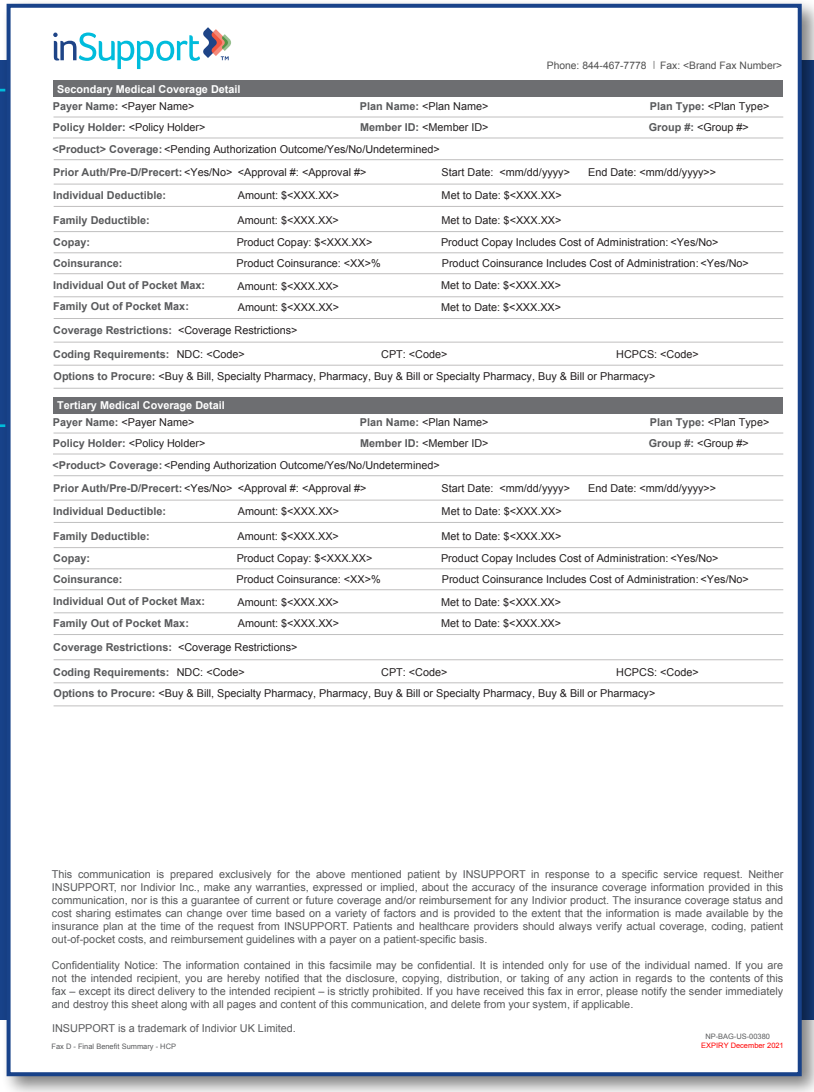
Fax D - Final Benefit Summary - HCP

NP-BAG-US-00380
EXPIRY December 2021

This section lists the coverage details for the patient's secondary insurance and will only be included in the Final Benefit Summary if applicable. Once the primary insurance is applied, a secondary claim can be filed through this insurance plan.

This section lists the coverage details for the patient's tertiary insurance and will only be included in the Final Benefit Summary if applicable. Tertiary insurance is a third policy and payer that may be billed for services.



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Secondary Medical Coverage Detail

Payer Name: <Payer Name>		**Plan Name:** <Plan Name>	**Plan Type:** <Plan Type>
Policy Holder: <Policy Holder>		**Member ID:** <Member ID>	**Group #:** <Group #>
<Product> Coverage: <Pending Authorization Outcome/Yes/No/Undetermined>			
Prior Auth/Pre-D/Precert: <Yes/No>	**<Approval #:** <Approval #>	Start Date: <mm/dd/yyyy>	End Date: <mm/dd/yyyy>>
Individual Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Copay:	Product Copay: $<XXX.XX>	Product Copay Includes Cost of Administration: <Yes/No>	
Coinsurance:	Product Coinsurance: <XX>%	Product Coinsurance Includes Cost of Administration: <Yes/No>	
Individual Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Coverage Restrictions: <Coverage Restrictions>			
Coding Requirements: NDC: <Code>		CPT: <Code>	HCPCS: <Code>
Options to Procure: <Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>			

Tertiary Medical Coverage Detail

Payer Name: <Payer Name>		**Plan Name:** <Plan Name>	**Plan Type:** <Plan Type>
Policy Holder: <Policy Holder>		**Member ID:** <Member ID>	**Group #:** <Group #>
<Product> Coverage: <Pending Authorization Outcome/Yes/No/Undetermined>			
Prior Auth/Pre-D/Precert: <Yes/No>	**<Approval #:** <Approval #>	Start Date: <mm/dd/yyyy>	End Date: <mm/dd/yyyy>>
Individual Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Copay:	Product Copay: $<XXX.XX>	Product Copay Includes Cost of Administration: <Yes/No>	
Coinsurance:	Product Coinsurance: <XX>%	Product Coinsurance Includes Cost of Administration: <Yes/No>	
Individual Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Coverage Restrictions: <Coverage Restrictions>			
Coding Requirements: NDC: <Code>		CPT: <Code>	HCPCS: <Code>
Options to Procure: <Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>			

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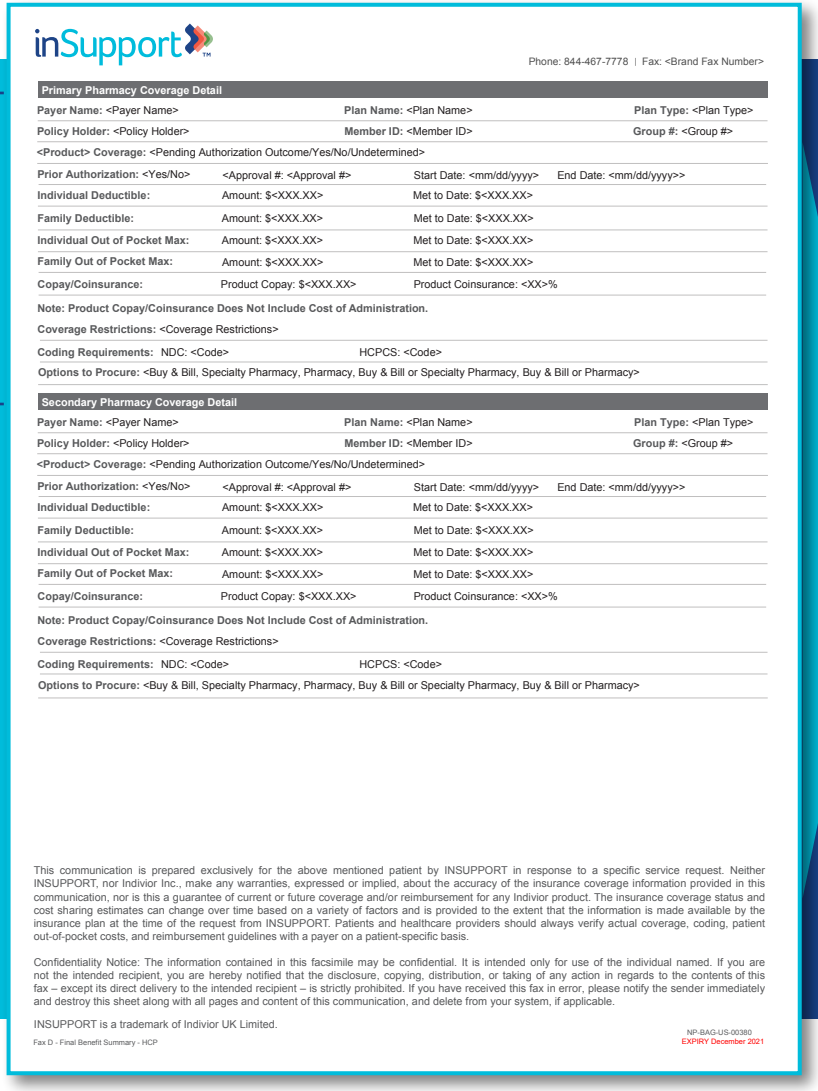
This section will provide the specifics of the patient's primary pharmacy coverage for medications.

This will appear only if the product is covered by the patient's health insurance company under the pharmacy benefit.

This section 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.



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Primary Pharmacy Coverage Detail

Payer Name: <Payer Name>		**Plan Name:** <Plan Name>	**Plan Type:** <Plan Type>
Policy Holder: <Policy Holder>		**Member ID:** <Member ID>	**Group #:** <Group #>
<Product> Coverage: <Pending Authorization Outcome/Yes/No/Undetermined>			
Prior Authorization: <Yes/No>	<Approval #: <Approval #>	Start Date: <mm/dd/yyyy>	End Date: <mm/dd/yyyy>>
Individual Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Individual Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Copay/Coinsurance:	Product Copay: $<XXX.XX>	Product Coinsurance: <XX>%	
Note: Product Copay/Coinsurance Does Not Include Cost of Administration.			
Coverage Restrictions: <Coverage Restrictions>			
Coding Requirements: NDC: <Code>		HCPCS: <Code>	
Options to Procure: <Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>			

Secondary Pharmacy Coverage Detail

Payer Name: <Payer Name>		**Plan Name:** <Plan Name>	**Plan Type:** <Plan Type>
Policy Holder: <Policy Holder>		**Member ID:** <Member ID>	**Group #:** <Group #>
<Product> Coverage: <Pending Authorization Outcome/Yes/No/Undetermined>			
Prior Authorization: <Yes/No>	<Approval #: <Approval #>	Start Date: <mm/dd/yyyy>	End Date: <mm/dd/yyyy>>
Individual Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Deductible:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Individual Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Family Out of Pocket Max:	Amount: $<XXX.XX>	Met to Date: $<XXX.XX>	
Copay/Coinsurance:	Product Copay: $<XXX.XX>	Product Coinsurance: <XX>%	
Note: Product Copay/Coinsurance Does Not Include Cost of Administration.			
Coverage Restrictions: <Coverage Restrictions>			
Coding Requirements: NDC: <Code>		HCPCS: <Code>	
Options to Procure: <Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>			

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EXPIRY December 2021

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This section provides information only for patients enrolled in a Medicare Part D prescription program.

After reaching the deductible, the patient pays a dollar amount or percentage of the cost of medications and the payer pays the rest.

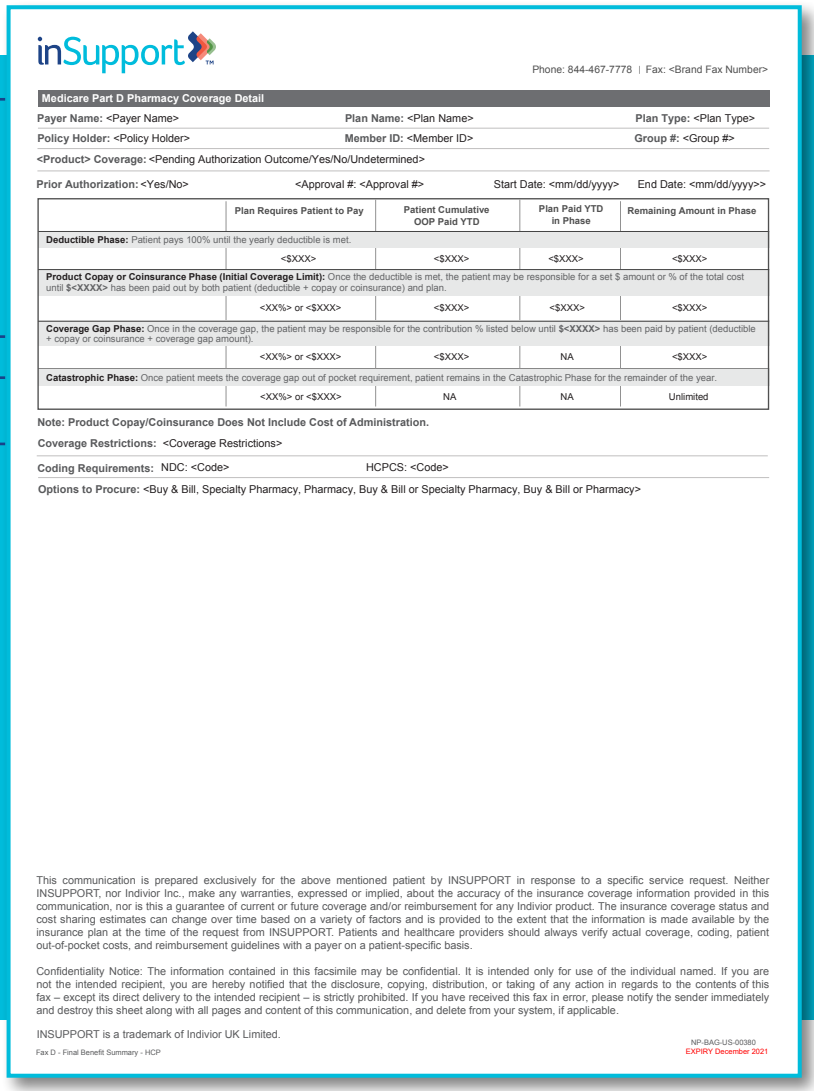
A coverage gap (also called the “donut hole”) begins after the patient and the payer have spent a certain amount for covered medications. In the coverage gap, the patient is responsible for a percentage of the cost of the medication.

Required out-of-pocket amounts may change each year.

Once a patient has spent a certain amount out-of-pocket, he/she is out of the coverage gap. Once out of the Medicare coverage gap for prescription drugs, the patient automatically receives “catastrophic coverage.” The patient will then pay only a small coinsurance or copay amount for covered medications for the rest of the calendar year.

Required out-of-pocket amounts may change each year.

This section will inform the HCP of any coverage restrictions, such as quantity limits or step edits, that may be required.



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Medicare Part D Pharmacy Coverage Detail

Payer Name: <Payer Name> **Plan Name:** <Plan Name> **Plan Type:** <Plan Type>

Policy Holder: <Policy Holder> **Member ID:** <Member ID> **Group #:** <Group #>

<Product> Coverage: <Pending Authorization Outcome/Yes/No/Undetermined>

Prior Authorization: <Yes/No> <Approval #: <Approval #> Start Date: <mm/dd/yyyy> End Date: <mm/dd/yyyy>>

	Plan Requires Patient to Pay	Patient Cumulative OOP Paid YTD	Plan Paid YTD in Phase	Remaining Amount in Phase
Deductible Phase: Patient pays 100% until the yearly deductible is met.				
	<$XXX>	<$XXX>	<$XXX>	<$XXX>
Product Copy or Coinsurance Phase (Initial Coverage Limit): Once the deductible is met, the patient may be responsible for a set $ amount or % of the total cost until **$<XXXX>** has been paid out by both patient (deductible + copay or coinsurance) and plan.				
	<XX%> or <$XXX>	<$XXX>	<$XXX>	<$XXX>
Coverage Gap Phase: Once in the coverage gap, the patient may be responsible for the contribution % listed below until **$<XXXX>** has been paid by patient (deductible + copay or coinsurance + coverage gap amount).				
	<XX%> or <$XXX>	<$XXX>	NA	<$XXX>
Catastrophic Phase: Once patient meets the coverage gap out of pocket requirement, patient remains in the Catastrophic Phase for the remainder of the year.				
	<XX%> or <$XXX>	NA	NA	Unlimited

Note: Product Copay/Coinsurance Does Not Include Cost of Administration.

Coverage Restrictions: <Coverage Restrictions>

Coding Requirements: NDC: <Code> HCPCS: <Code>

Options to Procure: <Buy & Bill, Specialty Pharmacy, Pharmacy, Buy & Bill or Specialty Pharmacy, Buy & Bill or Pharmacy>

NP-BAG-US-00380
EXPIRY December 2021

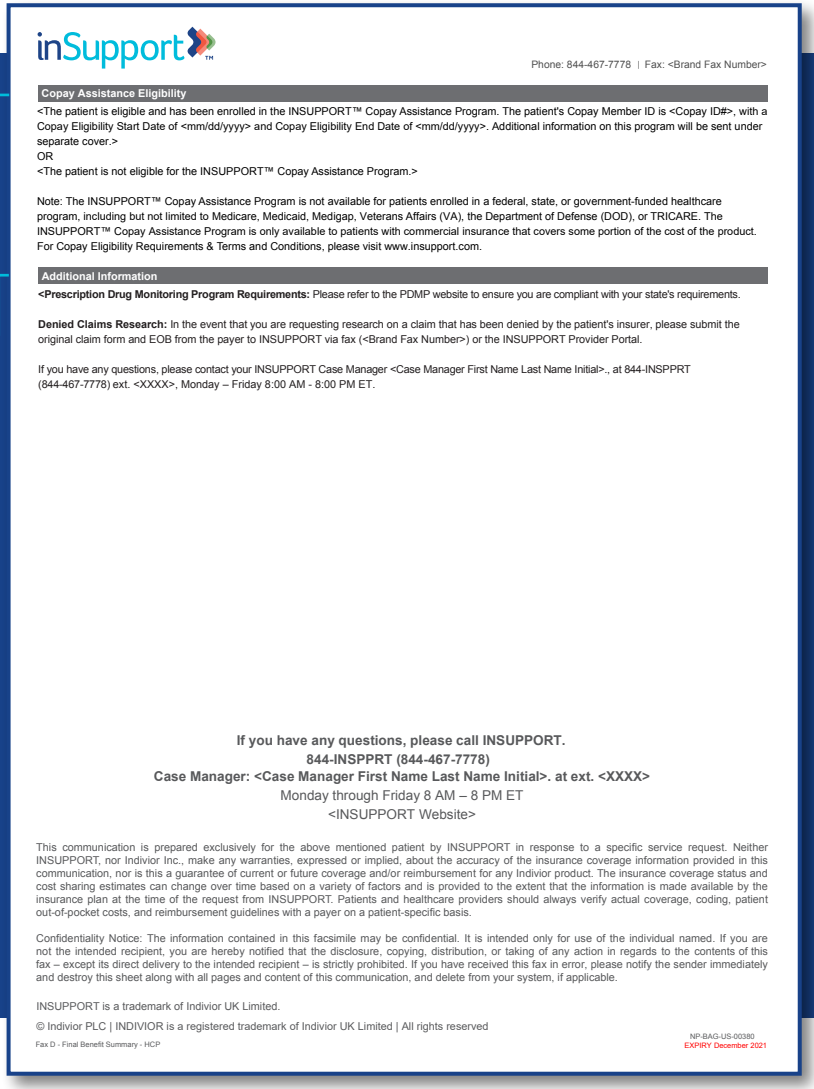
The individual or entity submitting a claim using INSUPPORT reimbursement information should ensure that all information submitted on or with the claim is accurate, complete, and applicable to the claim being filed. The appropriateness of filing any particular claim is and remains the responsibility of that claim’s submitter based on the submitter’s own judgment.

- Contact a Field Reimbursement Specialist for more information or to schedule an in-office meeting
- Call INSUPPORT at **844-INSPPRT** (844-467-7778) between 8:00 AM and 8:00 PM ET
- Visit **www.insupport.com**

Copay assistance programs may help eligible, commercially insured patients lower their out-of-pocket responsibility.

This section of the Benefit Summary will populate according to whether or not the patient is determined to be eligible for the INSUPPORT Copay Assistance Program.*

This section provides other details such as reminders and contact information for INSUPPORT.



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Copay Assistance Eligibility

<The patient is eligible and has been enrolled in the INSUPPORT™ Copay Assistance Program. The patient's Copay Member ID is <Copay ID#>, with a Copay Eligibility Start Date of <mm/dd/yyyy> and Copay Eligibility End Date of <mm/dd/yyyy>. Additional information on this program will be sent under separate cover.>
OR
<The patient is not eligible for the INSUPPORT™ Copay Assistance Program.>

Note: The INSUPPORT™ Copay Assistance Program is not available for patients enrolled in a federal, state, or government-funded healthcare program, including but not limited to Medicare, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DOD), or TRICARE. The INSUPPORT™ Copay Assistance Program is only available to patients with commercial insurance that covers some portion of the cost of the product. For Copay Eligibility Requirements & Terms and Conditions, please visit www.insupport.com.

Additional Information

<Prescription Drug Monitoring Program Requirements: Please refer to the PDMP website to ensure you are compliant with your state's requirements.

Denied Claims Research: In the event that you are requesting research on a claim that has been denied by the patient's insurer, please submit the original claim form and EOB from the payer to INSUPPORT via fax (<Brand Fax Number>) or the INSUPPORT Provider Portal.

If you have any questions, please contact your INSUPPORT Case Manager <Case Manager First Name Last Name Initial>., at 844-INSPPRT (844-467-7778) ext. <XXXX>, Monday – Friday 8:00 AM - 8:00 PM ET.

If you have any questions, please call INSUPPORT.
844-INSPPRT (844-467-7778)
Case Manager: <Case Manager First Name Last Name Initial>. at ext. <XXXX>
Monday through Friday 8 AM – 8 PM ET
<INSUPPORT Website>

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EXPIRY December 2021

*The INSUPPORT Copay Assistance Program is valid ONLY for patients with private insurance who are prescribed SUBLOCADE® (buprenorphine extended-release) for on-label use. 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. Other restrictions apply. Visit insupport.com to view complete Terms & Conditions.