inSupport®

INSUPPORT® Patient Enrollment Form

User Guide

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.**

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

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

P-BAG-US-00781 EXPIRY September 2022

Once all required information is completed on this form, please complete the fax information here and return ALL PAGES to INSUPPORT.

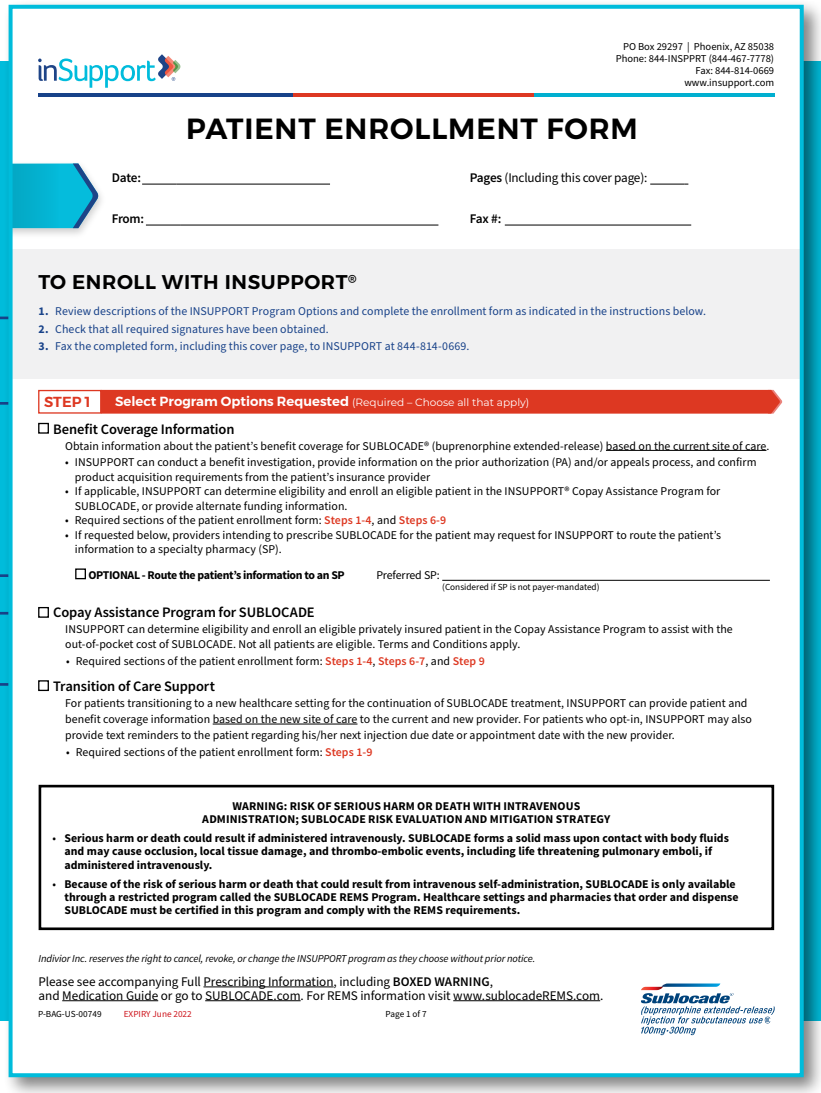
Step 1: This step is required. For each program option, there is a description of the information provided by INSUPPORT and the required steps to be completed on the Form for patient enrollment. Please select all applicable options.

You may request to route your patient's benefit information to a specialty pharmacy (SP) by checking this box. Learn more about the SPs that are in SUBLOCADE's restricted network by using this QR code.

If routing is not requested, you will still receive the patient's benefit coverage information for all applicable benefit types. You may then choose to acquire SUBLOCADE for your patient when and how you prefer.

Please note that patient eligibility determination for the INSUPPORT® Copay Assistance Program is included in the Benefit Coverage Information option, so it is not necessary to also check the box to request Copay Assistance.

This option is only applicable to patients who will be leaving your site of care in the future and transitioning to a new healthcare provider. Learn more about Transition of Care Support by using this QR code.



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PO Box 29297 | Phoenix, AZ 85038
Phone: 844-INSPPRT (844-467-7778)
Fax: 844-814-0669
www.insupport.com

PATIENT ENROLLMENT FORM

Date: _____ **Pages** (Including this cover page): _____

From: _____ **Fax #:** _____

TO ENROLL WITH INSUPPORT®

1. Review descriptions of the INSUPPORT Program Options and complete the enrollment form as indicated in the instructions below.
2. Check that all required signatures have been obtained.
3. Fax the completed form, including this cover page, to INSUPPORT at 844-814-0669.

STEP 1 **Select Program Options Requested** (Required – Choose all that apply)

☐ **Benefit Coverage Information**

Obtain information about the patient's benefit coverage for SUBLOCADE® (buprenorphine extended-release) based on the current site of care.

- INSUPPORT can conduct a benefit investigation, provide information on the prior authorization (PA) and/or appeals process, and confirm product acquisition requirements from the patient's insurance provider
- If applicable, INSUPPORT can determine eligibility and enroll an eligible patient in the INSUPPORT® Copay Assistance Program for SUBLOCADE, or provide alternate funding information.
- Required sections of the patient enrollment form: Steps 1-4, and Steps 6-9
- If requested below, providers intending to prescribe SUBLOCADE for the patient may request for INSUPPORT to route the patient's information to a specialty pharmacy (SP).

☐ **OPTIONAL - Route the patient's information to an SP** Preferred SP: _____
(Considered if SP is not payer-mandated)

☐ **Copay Assistance Program for SUBLOCADE**

INSUPPORT can determine eligibility and enroll an eligible privately insured patient in the Copay Assistance Program to assist with the out-of-pocket cost of SUBLOCADE. Not all patients are eligible. Terms and Conditions apply.

- Required sections of the patient enrollment form: Steps 1-4, Steps 6-7, and Step 9

☐ **Transition of Care Support**

For patients transitioning to a new healthcare setting for the continuation of SUBLOCADE treatment, INSUPPORT can provide patient and benefit coverage information based on the new site of care to the current and new provider. For patients who opt-in, INSUPPORT may also provide text reminders to the patient regarding his/her next injection due date or appointment date with the new provider.

- Required sections of the patient enrollment form: Steps 1-9

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- **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 the INSUPPORT program as they choose without prior notice.

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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Sublocade® (buprenorphine extended-release) injection for subcutaneous use® 100mg-300mg

For **BOXED WARNING** refer to front page; See accompanying Full Prescribing Information, including **BOXED WARNING** and Medication Guide, or go to SUBLOCADE.com.

Step 2: This 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 provider information should be provided in Step 5.

Please complete the practice contact information to indicate a specific person for INSUPPORT to contact regarding this case, if needed.

Step 3: The information in this section must be completed by the treatment provider and is necessary to validate FDA-approved use of SUBLOCADE® (buprenorphine extended-release), as well as for completion of the benefit investigation process with the patient's insurance provider, where applicable.

Step 4: 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, as well as the Provider Certification and Terms and Conditions of the INSUPPORT® Copay Assistance Program, where applicable, for the patient being enrolled.

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

STEP 2 Current Provider Information (To be completed by the provider only)

*Provider First Name _____ *Provider Last Name _____

*Provider NPI # _____ State License # _____ DEA # _____

*Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional

Practice/Facility Name _____ *Practice NPI # _____ Practice Tax ID # _____

*Practice Address _____ *City _____ *State _____ *ZIP _____

*Practice Phone Number ( ) _____ *Practice Fax Number ( ) _____

Practice Contact First and Last Name _____ Practice Contact Phone Number ( ) _____

STEP 3 Treatment Information (To be completed by the provider only)

*ICD-10 Diagnosis Code: _____ Scheduled Injection Date: __/__/__(if known)

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

Reminder: If using a specialty pharmacy, please remember to send a valid prescription for SUBLOCADE directly to the pharmacy.

STEP 4 Provider Attestation (Required)

By signing below, I certify the following:

1) The information inserted in Steps 2, 3, 5, 6, and 7 and 8 (as applicable) of 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 Certification and Terms and Conditions for the INSUPPORT® Copay Assistance Program, as applicable, as well as this Provider Attestation.

*Provider Signature _____ *Date __/__/__

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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Sublocade® (buprenorphine extended-release) injection for subcutaneous use ®. 100mg-300mg

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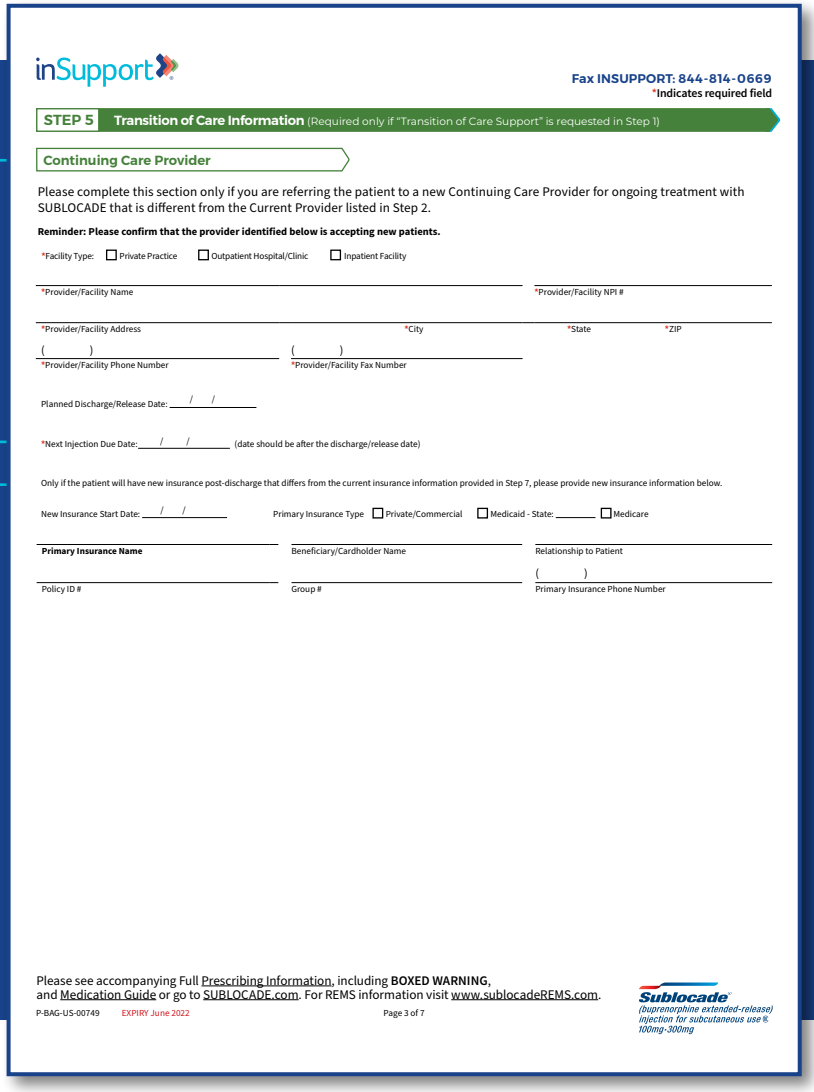
Step 5: For patients enrolled in Transition of Care only, provide the new continuing care provider information here. If you need more information on how to locate a new community provider for your patient, please contact INSUPPORT.

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. For patients who opt-in on page 6, this is used to provide a patient text reminder prior to this due date.

For Transition of Care Support, INSUPPORT conducts a benefit investigation for the patient at the site of care above. If your patient's current health insurance will not change post discharge/release (provided in Step 7), no information is required here.

If the patient's insurance information will change, please provide as much information here as possible for INSUPPORT.



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

STEP 5 **Transition of Care Information** (Required only if "Transition of Care Support" is requested in Step 1)

Continuing Care Provider

Please complete this section only if you are referring the patient to a new Continuing Care Provider for ongoing treatment with SUBLOCADE that is different from the Current Provider listed in Step 2.

Reminder: Please confirm that the provider identified below is accepting new patients.

*Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility

*Provider/Facility Name | *Provider/Facility NPI #

*Provider/Facility Address | *City | *State | *ZIP

( ) *Provider/Facility Phone Number | ( ) *Provider/Facility Fax Number

Planned Discharge/Release Date: ___/___/___

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

Only if the patient will have new insurance post-discharge that differs from the current insurance information provided in Step 7, please provide new insurance information below.

New Insurance Start Date: ___/___/___ Primary Insurance Type ☐ Private/Commercial ☐ Medicaid - State: _____ ☐ Medicare

Primary Insurance Name | Beneficiary/Cardholder Name | Relationship to Patient

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

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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Step 6: All patient contact information is required except the Government Issued Identification Number and Email Address.

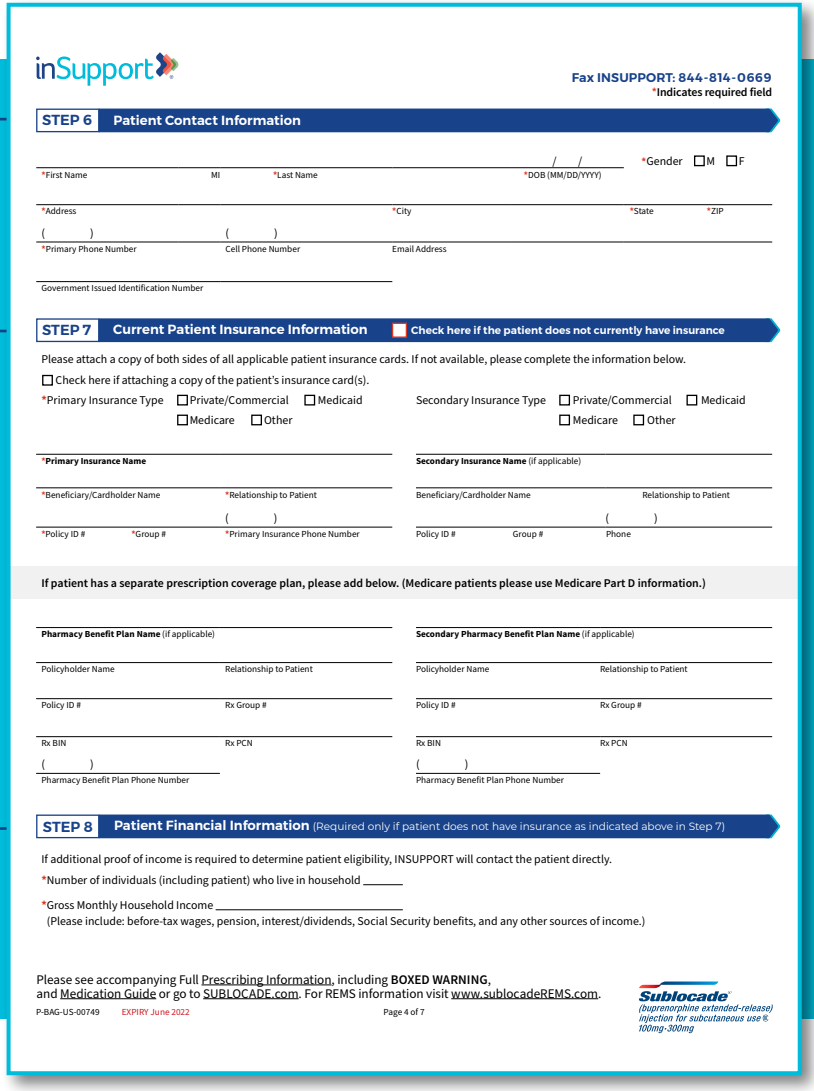
Step 7: If the patient is not insured, please ensure you check the box indicating the patient does not have insurance and have the patient complete Step 8.

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.

Step 8: The information in this section is required only if Benefit Coverage Information is requested in Step 1, and the box in Step 7 is checked indicating that patient does not currently have insurance.

This financial information is used by INSUPPORT to provide information on possible alternate funding sources, if identified.



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

STEP 6 Patient Contact Information

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

*Address | *City | *State | *ZIP

*Primary Phone Number | Cell Phone Number | Email Address

Government Issued Identification Number

STEP 7 Current Patient Insurance Information ☐ Check here if the patient does not currently have insurance

Please attach a copy of both sides of all applicable patient insurance cards. If not available, please complete the information below.

☐ Check here if attaching a copy of the patient's insurance card(s).

*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 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

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 8 Patient Financial Information (Required only if patient does not have insurance as indicated above in Step 7)

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.)

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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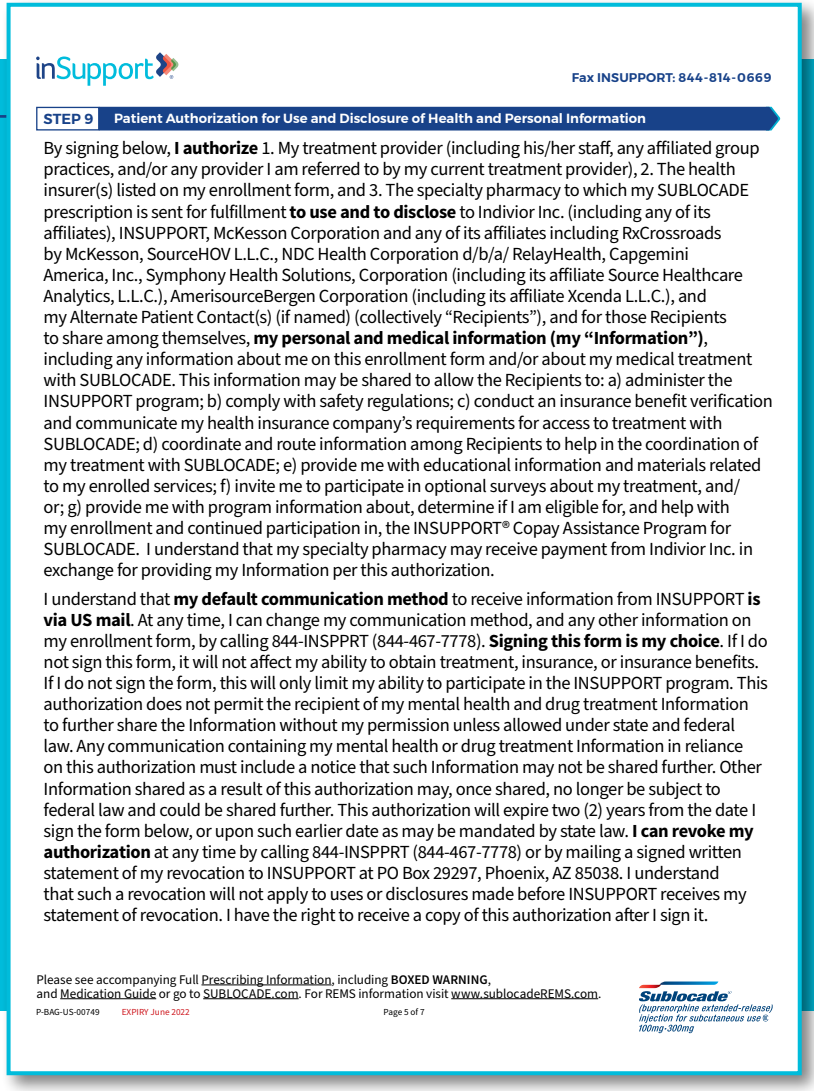
Step 9: The patient should review this page prior to completing the Authorization. The Authorization includes, but is not limited to, details of why and to whom INSUPPORT may use or disclose the patient's personal and medical information.



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Fax INSUPPORT: 844-814-0669

STEP 9 **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.

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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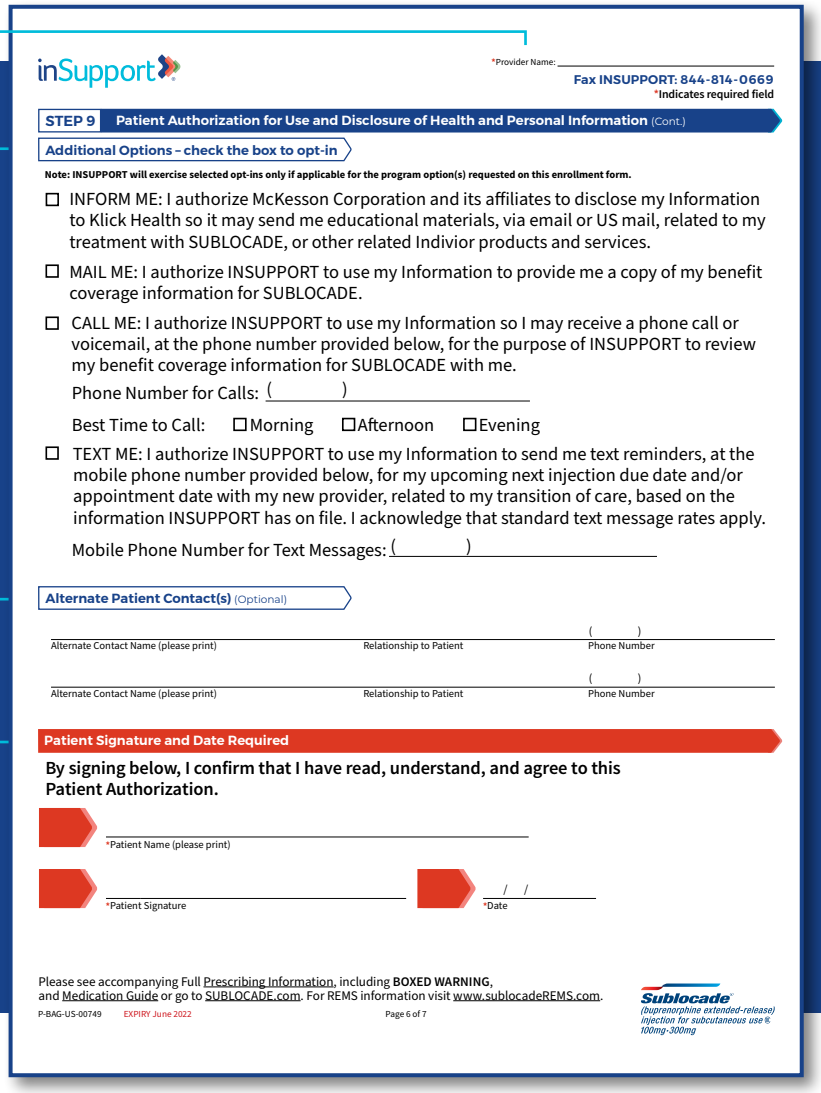
The Provider Name is required to ensure that the patient's authorization is correctly associated with the intended treatment provider.

To request any of the additional options listed in this section, the patient must check the box to opt-in. These are optional and allow the patient to obtain additional information, if desired.

The patient may designate Alternate Patient Contacts here to allow INSUPPORT to share information related to the patient's requested program option(s) with the individual(s) named. This information is optional.

In order to initiate any request from INSUPPORT, the patient's name, signature, and date are required. Any Enrollment Form received by INSUPPORT with an incomplete Patient Authorization will be returned to the HCP 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 authorization electronically at www.insupportportal.com.



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*Provider Name: _____

Fax INSUPPORT: 844-814-0669

*Indicates required field

STEP 9 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 enrollment 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 / /

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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This page provides the Terms and Conditions necessary for participation in the INSUPPORT® Copay Assistance Program. If the patient is requesting Benefit Coverage Information or the Copay Assistance Program in Step 1, 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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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.
- 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 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 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.

Provider Certification: The INSUPPORT® Copay Assistance Program

By signing above, I certify that:

1) I have prescribed the Program Product to the patient identified in the Patient Contact Information section of this Form (the "Patient") in the exercise of my independent medical judgement for its FDA-approved indication; 2) I have read the Terms and Condition of the INSUPPORT® Copay Assistance Program and, to the best of knowledge, the patients meets the criteria set forth in the Terms and Conditions; 3) I/my office will not seek reimbursement for any offering or benefit provided by or through INSUPPORT from any government program or third-party insurer; 4) 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 patients; 5) 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 a means of promoting my services or the Program Product; 6) 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; 7) 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; 8) If 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 amount received back to the Patient; 9) 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.

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.

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

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

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For **BOXED WARNING** refer to front page; See accompanying Full Prescribing Information, including **BOXED WARNING** and Medication Guide, or go to SUBLOCADE.com.

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