Certification Form for the INSUPPORT™ Copay Assistance Program for PERSERIS™ (risperidone) for extended-release injectable suspension

Prior to submitting copay claims, please complete and sign the certification for the INSUPPORT™ Copay Assistance Terms and Conditions for PERSERIS below. If you have submitted a signed INSUPPORT Patient Enrollment Form for PERSERIS, you do not need to complete this form. **Please fax both pages to INSUPPORT at 833-404-4897.**

Provider Name ____________________ Provider NPI ____________________

Practice Name ____________________

Practice Address ____________________

Practice Phone ____________________ Practice Fax ____________________

Practice Tax ID # ____________________ Practice NPI # ____________________

Patient Eligibility Requirements:

- Patient must have private health insurance that provides coverage for some portion of the cost of PERSERIS under a medical or pharmacy benefit plan. The INSUPPORT™ 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 INSUPPORT™ 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 PERSERIS.

Program Enrollment:

- The INSUPPORT™ Copay Assistance Program is not insurance.
- 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 INSUPPORT™ 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:

- Patient may pay as little as $5 per injection of PERSERIS throughout the eligibility period in this Program. Program exhausts after 13 doses or $8,000, whichever comes first.
  - 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.

inSupport™ Copay Assistance

- If PERSERIS 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 PERSERIS and submission of the claim by the patient's provider for the cost of PERSERIS.
- The benefit available under the INSUPPORT™ Copay Assistance Program is valid for the patient's out-of-pocket cost for PERSERIS 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 PERSERIS. Claims for PERSERIS must be submitted by the provider to patient's private health insurance separately from other services and products.
- Patient and provider agree not to seek reimbursement for any or all of the benefit received by the patient through the INSUPPORT™ Copay Assistance Program.
- Patients will notify INSUPPORT immediately upon any change in health insurance if still receiving benefits through the INSUPPORT™ Copay Assistance Program.
- The INSUPPORT™ 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 INSUPPORT™ Copay Assistance Program.
- Indivior Inc. reserves the right to rescind, revoke, or amend the INSUPPORT™ Copay Assistance Program at any time without notice.

By signing below, I certify that:

1) The information provided in this certification form is accurate to the best of my knowledge; 2) The prescribed medication is medically appropriate for the patient identified; 3) My practice or pharmacy has obtained written authorization from each patient to disclose the patient's personal health information and any other information on this form as may be required by INSUPPORT 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); 4) 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; 5) INSUPPORT may contact me for additional information in the following ways: (including but not limited to) email, fax, and telephone; 6) Completing this form does not ensure that a 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 represents 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; 7) I understand that Indivior Inc. reserves the right, at any time and without notice, to rescind, revoke, or amend any INSUPPORT services; 8) I/my office will not seek reimbursement for any offering provided by or through INSUPPORT from any government program or third-party insurer; 9) I have read, understand, and agree to the Terms and Conditions of the INSUPPORT™ Copay Assistance Program, as applicable.

Provider Signature Required (No stamps allowed)

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Provider Name

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Provider Signature Date

PROVIDERS ARE RESPONSIBLE TO COMPLY WITH STATE-SPECIFIC PRESCRIPTION AND/OR COPAY LAWS AND REGUALTIONS AS APPLICABLE.

If applicable, please complete the fields below for any claim(s) submitted to the INSUPPORT™ Copay Assistance Program.		
Patient First and Last Name	**Patient Copay ID**	**INSUPPORT™ Copay Claim Number**

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