PO Box 29297 | Phoenix, AZ 85038
Phone: 844-INSPPRT (844-467-7778)
Fax: 833-404-4897
www.insupport.com

INSUPPORT® PATIENT AUTHORIZATION

TO COMPLETE THIS FORM:

1 Complete the Patient Contact Information Section on page 2

2 Review the Terms and Conditions and Patient Certification for the INSUPPORT® Copay Assistance Program for PERSERIS® (risperidone), if applicable

3 Read, understand, and complete the Patient Authorization on pages 3 and 4

- Complete any optional sections of the form on page 4, if desired
- **Complete all required fields on page 4: Provider Name and Phone (top of page), your Printed Name, Signature, and Date (bottom of page).**

4 Submit the completed Patient Authorization Form (all pages) to INSUPPORT via DocuSign or ask your HCP to submit via fax to 833-404-4897

What is the most important information I should know about PERSERIS?

Drugs like PERSERIS that are used to treat schizophrenia can cause serious side effects, including an increased risk of death in elderly people who are confused, have memory loss, and have lost touch with reality (dementia-related psychosis). PERSERIS is not approved to treat dementia-related psychosis and it has not been studied in elderly people with dementia-related psychosis.

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 PERSERIS.com.

PERSERIS® (risperidone) for extended-release injectable suspension 90 mg · 120 mg

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*Indicates required field

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

Terms and Conditions: The INSUPPORT® Copay Assistance Program for PERSERIS® (risperidone) for extended-release injectable suspension

To receive benefits under the INSUPPORT® Copay Assistance Program for PERSERIS, the patient must be determined as eligible and be enrolled in the INSUPPORT® Copay Assistance Program.

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 INSUPPORT® 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 US 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 INSUPPORT® 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.
- 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 the Program. Program exhausts after 13 doses or $8,000, whichever comes first.
  - If the patient's financial responsibility for the medication is greater than the maximum copay assistance amount per year, the patient will be responsible for any remaining costs not covered by the copay assistance benefit.
- If PERSERIS is covered under the patient's medical benefit plan:
  - An Explanation of Benefits (EOB) from the 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 PERSERIS. Claims for PERSERIS must be submitted by the provider to the 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.
- Patient 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.

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 (available on page 5 of the Patient Enrollment Form or on www.insupport.com), and that I meet the Program's eligibility requirements, to include the following:

- I have private health insurance that provides coverage for some portion of the cost of PERSERIS under a medical or pharmacy benefit plan.
- I do not have government insurance, including, but not limited to Medicare, Medicaid, Medigap, VA, DoD, TRICARE, CHAMPVA or any other federally or state funded government assisted program. I understand that I become eligible for benefits from state, federal or government funded programs, such as those listed above, to help pay for my prescription of PERSERIS, that I will no longer be eligible to participate in this Program. 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 those listed above.
- I will not seek reimbursement for the cost of PERSERIS (in full or in part) from any third-party payers, including a flexible spending or healthcare savings account.
- I will notify INSUPPORT immediately if my health insurance status changes in the future, if I obtain any new health insurance plan, so that INSUPPORT can confirm my continued eligibility in the Program.

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

PERSERIS® (risperidone) for extended-release injectable suspension 90 mg · 120 mg

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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 pharmacy(ies) to which my PERSERIS prescription is sent for fulfillment **to use and 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 any information about me on this enrollment form and/or about my medical treatment with PERSERIS. 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 PERSERIS; d) coordinate and route Information among Recipients to help in the coordination of my treatment with PERSERIS; 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 PERSERIS.

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. Any 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, 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.

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*Provider Name: _____ Case ID (if known): _____

*Provider Phone: _____

*Indicates required field

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 for enrollment.

☐ MAIL ME: I authorize INSUPPORT to use my Information to provide me a copy of my benefit coverage information for PERSERIS.

☐ 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 PERSERIS 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
		( )
		( )

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 / /

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