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

# PATIENT AUTHORIZATION AND CONSENT

## TO COMPLETE THIS FORM:

1 Review the Terms and Conditions for the Copay Assistance Program on page 2, if applicable.

2 Read and Understand the Patient Authorization and Consent Form on page 3.

- At the top of the form, please provide the name of your healthcare professional (HCP), and your Patient ID (if known)
- Complete any optional sections of the form, if desired
- **Sign and date the bottom of the form**

3 Submit the completed Patient Authorization and Consent Form (page 3 only) to INSUPPORT via fax at **833-404-4897**, or the INSUPPORT™ Patient Portal at www.myportal.insupport.com.

**WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA RELATED PSYCHOSIS**

**Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. PERSERIS™ is not approved for the treatment of patients with dementia-related psychosis and has not been studied in this population.**

*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

inSupport™

Fax INSUPPORT: 833-404-4897

## 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.

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

inSupport™

Provider Name: _____ Patient ID (if known): _____

**Fax INSUPPORT: 833-404-4897**

## Patient Authorization and Consent

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 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 protected heath information, including information about my mental health condition(s)**, including information on my enrollment form, and about my medical treatment with PERSERIS (taken together, "Information"). This Information can be shared **for the specific purposes**, and as needed, to allow INSUPPORT to provide the requested services. The purpose(s) may include one or more of the following: a) to facilitate the enrollment process for the services I have requested on my enrollment form; b) to conduct insurance benefit verification and communicate my health insurance company's requirements for access to treatment with PERSERIS; c) to coordinate services and route information between Recipients to help in the coordination of my treatment with PERSERIS; d) to provide me with educational information and materials related to my enrolled services; e) to invite me to participate in optional surveys about my treatment; and/or f) to provide me with program information about, determine if I am eligible for, and help with my continued participation in, the INSUPPORT™ Copay Assistance Program for PERSERIS. 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; 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.

## Patient Certification for the INSUPPORT™ Copay Assistance Program (Private or Commercial insurance only)

By signing below, I certify that I have read, understand, and agree to the Terms and Conditions of the INSUPPORT™ Copay Assistance Program (available on page 2 of this 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.

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

**Only applicable if Full Hub Services is requested on this enrollment form:**

☐ I would like to receive a copy of my benefit coverage information for PERSERIS via direct mail or the INSUPPORT™ Patient Portal, based on my communication preferences established with INSUPPORT.

☐ I would like to receive a phone call, or receive a voicemail, at the number provided below specifically for the purpose of INSUPPORT to review my benefit coverage information for PERSERIS with me. 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

## Authorized Representative (Optional)

By completing this section, 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 PERSERIS, and communicate my ongoing preferences and need for INSUPPORT services. I understand that Indivior Inc. 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.**

_____

Patient Name (Please print)

X _____

Patient Signature Date

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