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

PATIENT ENROLLMENT FORM

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

From: _____ **Fax #:** _____

TO ENROLL WITH INSUPPORT®

1. Review descriptions of 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 833-404-4897

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

☐ Transition of Care Support

For PERSERIS® (risperidone) patients transitioning to a new healthcare setting to 1) continue PERSERIS treatment with a new continuing care provider, and/or 2) receive a PERSERIS injection from an alternate site of care, INSUPPORT can provide patient and benefit coverage information based on the new site of care to the current and new provider/facility. 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 1-8**

☐ Benefit Coverage Information

Obtain information about the patient's benefit coverage for PERSERIS 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 PERSERIS, or provide alternate funding information.
- Required sections of the patient enrollment form: **Steps 1-3**, and **Steps 5-8**
- If requested below, INSUPPORT may route the patient's information and prescription to a pharmacy for fulfillment.

○ **OPTIONAL - Route the patient's information and prescription to a pharmacy**

Preferred Pharmacy: _____ ( ) _____ ( ) _____
(Considered if Pharmacy is not payer-mandated) Preferred Pharmacy Phone Number Preferred Pharmacy Fax Number

☐ Copay Assistance Program for PERSERIS

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 PERSERIS. Not all patients are eligible. Terms and Conditions apply.

- Required sections of the patient enrollment form: **Steps 1-3**, **Steps 5-6**, and **Step 8**.

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
*Indicates required field

STEP 2 Current Provider Information

*First Name _____ *Last Name _____

*Provider NPI # _____ State License # _____

*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 Prescription

***Patient Name:** _____ ***ICD-10 Diagnosis Code:** _____

***Prescribed Dose (check one only):** ☐ PERSERIS 90 mg ☐ PERSERIS 120 mg ***Qty:** _____ ***Refills:** _____

Directions: _____

By signing below, I certify the following:

1) The information inserted in Steps 2, 3, 4, 5, and 6 and 7 (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 judgement 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); 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) INSUPPORT may, on my behalf, forward this prescription to a pharmacy for fulfillment if requested; 6) 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; 7) 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; 8) I agree that in no event shall Indivior be liable for any damages resulting from or relating to requested or provided information from INSUPPORT; 9) I understand that Indivior Inc. reserves the right, at any time and without notice, to rescind, revoke, or amend the INSUPPORT program.

***Prescriber Signature Required (No stamps allowed)** – PLEASE SIGN AND DATE ONLY ONE LINE BELOW

Dispense as Written _____ **Date** _____ -OR- **Substitutions Permitted** _____ **Date** _____

PRESCRIBERS ARE RESPONSIBLE TO COMPLY WITH STATE-SPECIFIC PRESCRIPTION REQUIREMENTS

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*Indicates required field

STEP 4 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 PERSERIS 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 Tax ID #

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

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

Planned Discharge/Release Date: ___/___/___

*Next Injection Due Date: ___/___/___ (post-discharge)

Only if the patient will have new insurance post-discharge that differs from the current insurance information provided in Step 6, 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

Alternate Site of Care for Injection Only

Please complete this section only if you are referring the patient to an alternate site of care to receive a PERSERIS injection.
Please CHECK ONLY ONE OPTION BELOW to indicate a PERSERIS Injection Network (PIN) location or other alternate site of care that is not in the PIN. (Please see https://www.insupport.com/specialty-product-2/hcp/injection-location-finder for PIN location information.)

☐ **PERSERIS Injection Network** *PIN Location ID **-OR-** *PIN Location Name | *PIN Zip Code

-OR-

☐ **Other Alternate Site of Care (Not in the PERSERIS Injection Network)**

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

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

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

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

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

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Fax INSUPPORT: 833-404-4897
*Indicates required field

STEP 5 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

STEP 6 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 7 Patient Financial Information (Required only if patient does not have insurance as indicated above in Step 6)

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.)

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

STEP 8 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.

STEP 8 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.

☐ 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 / /

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

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.

P-RAG-US-00303 EXPIRY June 2022

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