

PATIENT ENROLLMENT FORM

TO ENROLL WITH INSUPPORT™

1. Review descriptions of INSUPPORT Services 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 to INSUPPORT at 833-404-4897

If the patient has completed the required portions of the enrollment form, enrollment can be completed by the treatment provider via the INSUPPORT Provider Portal at www.providerportal.insupport.com.

INSUPPORT SERVICES

Full Hub Services

To initiate a Benefit Investigation of the patient's insurance coverage for PERSERIS™ (risperidone) for extended-release injectable suspension, based on site of care, and/or obtain information on any associated prior authorizations (PA), appeals, and financial assistance – including, if applicable, determine eligibility and enroll patient in the INSUPPORT™ Copay Assistance Program, or provide alternate sources of funding information, and/or route patient information and prescription to a pharmacy, please provide:

- Required sections of the patient enrollment form: **Steps 1–8**
- **Please Note:** If site of care is a PERSERIS Injection Network (PIN) location, specific information related to PA requirements may not be provided by INSUPPORT and may be provided by the PIN location

Insurance Verification Only

To confirm the patient's insurance coverage for PERSERIS, please provide:

- Required sections of the patient enrollment form: **Steps 1–3** and **Steps 5–7**
- **Please Note:** If a commercial patient, you may also select the “Copay Assistance Program” service. See below

Copay Assistance Program

Copay assistance is available for eligible privately insured patients to assist with the out-of-pocket cost of PERSERIS. Not all patients are eligible. Terms and Conditions apply. To apply, please provide:

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

Alternate Funding Research

To initiate research into alternate sources of funding for an uninsured or underinsured patient, please provide:

- Required sections of the patient enrollment form: **Steps 1–6** and **Step 8**

Denied Claim Research

To initiate a review and research of a patient's denied claim, please provide:

- The Explanation of Benefits and a copy of the denial correspondence from the patient's health insurer
- Required sections of the patient enrollment form: **Steps 1–3** and **Steps 5–6**

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.

Step 1 Select INSUPPORT Service

- Full Hub Services
 Insurance Verification Only
 Copay Assistance Program
 Alternate Funding Research
 Denied Claim Research

STEP 2 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 3 Patient Insurance Information

Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.

- Patient is insured Y N
 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 4 Patient Financial Information (Required for Alternate Funding Research)

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.)

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

STEP 5 Prescription

Patient Name: _____ ICD-10 Diagnosis Code: _____

Prescribed Dose: PERSERIS 90 mg PERSERIS 120 mg Qty: _____ Refills: _____

Directions: _____

By signing below, I certify that:

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

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

_____ Dispense as Written _____ Date _____ Substitutions Permitted _____ Date _____

PRESCRIBERS ARE RESPONSIBLE TO COMPLY WITH STATE-SPECIFIC PRESCRIPTION REQUIREMENTS

STEP 6 Provider Information

First Name _____ Last Name _____

Provider NPI # _____ State License # _____ Provider Tax ID # _____

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

Practice Address _____ City _____ State _____ Zip _____

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Practice Phone Number _____ Practice Fax Number _____

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Practice Contact First and Last Name _____ Practice Contact Phone Number _____ Practice Contact Email Address _____

Preferred Product Acquisition:

Specialty Distributor - Buy and Bill

Specialty Pharmacy

(Used if pharmacy is not payer-mandated) Preferred Pharmacy Name _____ Phone Number _____ Fax Number _____

STEP 7 Alternate Site of Care - PLEASE CHECK ONLY ONE BOX BELOW

Please indicate PERSERIS Injection Network (PIN) or Alternate Site of Care (non-PIN) below (Please see insupport.com for PIN Locator information)

PERSERIS Injection Network _____ -OR- _____

-OR- PIN Location ID _____ PIN Location Name _____ PIN Zip Code _____

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

Facility Type: Pharmacy Physician Office Inpatient Hospital Outpatient Hospital Other: _____

Facility Name _____ Facility NPI # _____ Facility Tax ID # _____

Facility Address _____ City _____ State _____ Zip _____

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Facility Phone Number _____ Facility Fax Number _____

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

STEP 8 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 health 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 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.

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

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

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.

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