For additional questions on how to complete the INSUPPORT Patient Enrollment Form:

- Contact your Field Reimbursement Specialist for information or to schedule an in-office meeting
- Call INSUPPORT at **844-INSPPRT** (844-467-7778) between 8:00 AM and 8:00 PM ET
- Visit **www.insupport.com**

Patients are not required to complete the requested information in these blank fields if filling out this form in the HCP's office for submission with the completed Enrollment Form to INSUPPORT. In the event that the patient's signature is not captured on the Authorization and Consent Form in the HCP office, patients may provide only this signed page to INSUPPORT, via fax or the Patient Portal, with the information in these blank fields completed. If the Enrollment Form has already been submitted to INSUPPORT by the HCP, the patient must obtain the INSUPPORT Patient ID from his or her HCP.

Step 8: The purpose of this step is to obtain the patient's authorization for the sharing of his or her personal and medical information by his or her treatment provider (or practice).

This section informs the patient about how and to whom information will be shared, for what purposes the information will be shared, and explains that the authorization is voluntary and can be revoked at any time.

If applicable to the services requested, the patient must certify that he or she meets eligibility requirements and Terms and Conditions of the INSUPPORT™ Copay Assistance Program*, as well as the requirements listed in this section, providing a signature on the Patient Authorization and Consent page.

To receive any of the optional services listed in this section, patients must check the box next to the service. Patients may opt-in to as many of the services as desired here.

If desired, the patient may designate an Authorized Representative here to allow INSUPPORT to share information related to the patient's requested services with the individual named.

In order to initiate Full Hub Services, Alternate Funding Research, and/or Denied Claim Research from INSUPPORT, the patient's signature is required in this section of the Patient Authorization and Consent form. Any Enrollment Form received by INSUPPORT without the patient signature for these services will be returned to the HCP for completion with the patient, or will require the patient to provide a signed stand-alone Patient Authorization and Consent Form to INSUPPORT.

inSupport | Provider Name: | Patient ID (if known):

Fax INSUPPORT: 833-404-4897

STEP 8 Patient Authorization and Consent

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

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

Authorized Representative (Optional)

Patient Signature

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

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*The INSUPPORT™ Copay Assistance Program is valid ONLY for patients with private insurance who are prescribed PERSERIS™ for on-label use. 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. Other restrictions apply. Visit insupport.com to view complete Terms & Conditions.

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

This section provides the terms and conditions necessary for participation in the INSUPPORT™ Copay Assistance Program.*

If the patient is enrolling in Full Hub Services or for the Copay Assistance Program, the patient and treatment provider must certify that this information has been read when providing their required signatures.

*The INSUPPORT™ Copay Assistance Program is valid ONLY for patients with private insurance who are prescribed PERSERIS™ (risperidone) for the FDA approved indication. 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. Other restrictions apply. Visit insupport.com to view complete Terms and Conditions.

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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:

Program Enrollment:

Program Benefit and Conditions:

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

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

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INSUPPORT™ Patient Enrollment Form

User Guide

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.

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

See accompanying full Prescribing Information, including **BOXED WARNING** or go to PERSERIS.com.

P-RAG-US-00075 EXPIRY October 2020

The INSUPPORT Patient Enrollment Form must be completed and submitted to INSUPPORT in order to initiate INSUPPORT services.
This Annotated Patient Enrollment Form will provide additional information on each section within the form.

This checklist provides an overview of the steps required to complete and submit the Enrollment Form to INSUPPORT.

The INSUPPORT services available to patients are listed here. Below the title of each service, there is additional information on what the service is designed to provide and what steps in the form must be reviewed and completed before the form is submitted.

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

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.

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

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

Step 1: In order to enroll the patient in a service provided by INSUPPORT, the box(es) next to the patient's requested service must be checked.

Please note that patient eligibility determination for the INSUPPORT™ Copay Assistance Program is included in Full Hub Services, so it is not necessary to check both boxes when requesting Full Hub Services and Copay Assistance.

Step 2: Patient name, address, and date of birth are required for enrollment for any INSUPPORT service.

Step 3: If a copy of the patient's health insurance card (front and back) is provided by the HCP with submission of the Patient Enrollment Form, the patient is not required to complete this section.

Only information applicable to the patient's insurance coverage must be provided. If the patient has both medical and pharmacy coverage, please provide information for both plans if available.

Step 4: The information in this section is required if the patient is requesting Alternate Funding Research as a stand-alone service or as part of Full Hub Services.

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Fax INSUPPORT: 833-404-4897

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 | **Secondary Insurance Name** (if applicable)
Beneficiary/Cardholder Name | Relationship to Patient | Beneficiary/Cardholder Name | Relationship to Patient
Policy ID # | Group # | Primary Insurance Phone Number | 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) | **Secondary Pharmacy Benefit Plan Name** (if applicable)
Policyholder Name | Relationship to Patient | Policyholder Name | Relationship to Patient
Policy ID # | Rx Group # | Policy ID # | Rx Group #
Rx BIN | Rx PCN | Rx BIN | Rx PCN
Pharmacy Benefit Plan Phone Number | 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.)

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

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

Step 5: The information in this section must be completed by the treatment provider and is necessary to validate FDA-approved use of PERSERIS™, as well as for completion of the benefit investigation process with the patient's insurance provider, where applicable.

The treatment provider's signature is required in this section to confirm the provider's agreement with both the statements listed in this section related to participation with INSUPPORT, as well as the Terms and Conditions of the INSUPPORT™ Copay Assistance Program, where applicable. The provider's signature is required here for all new patient enrollments in INSUPPORT.

Step 6: Provider information is required for the enrollment of new patients in INSUPPORT.

For patients enrolling in Full Hub Services, the treatment provider may select their preferred mode of product acquisition here, as well as their preferred pharmacy, if applicable. The benefit investigation will determine the procurement options for the patient as communicated by the patient's insurance provider. Provider preferences may be considered if there are no specific mandates made by the patient's insurance provider.

Step 7: For patients requesting to receive their PERSERIS prescription at an alternate site of care, only one of the two options in this step should be checked and the required information should be provided.

To find a location in the PERSERIS™ Injection Network (PIN), you may go to the PIN locator on www.insupport.com.

inSupport™

Fax INSUPPORT: 833-404-4897

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:

[…]

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
Practice Phone Number | Practice Fax Number
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 | PIN Location ID | -OR- | PIN Location Name | PIN Zip Code

-OR-

☐ 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
Facility Phone Number | Facility Fax Number

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