

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, upon 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.

Provider Name: _____ Patient ID (if known): _____
Fax INSUPPORT: 833-404-4897

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) 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 25297, 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 federal 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 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.

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

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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.

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™
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injectable suspension
90 mg - 120 mg

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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.

*The INSUPPORT™ Copay Assistance Program is valid ONLY for patients with private insurance who are prescribed PERSERIS™ 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.

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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.

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

PATIENT ENROLLMENT FORM

TO ENROLL WITH INSUPPORT™

- Review descriptions of INSUPPORT Services and complete the enrollment form as indicated in the instructions below
- Check that all required signatures have been obtained
- 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 1-6**
- 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.
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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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inSupport
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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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 method 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.

For **BOXED WARNING** refer to front page; see accompanying full Prescribing Information, including **BOXED WARNING** or go to PERSERIS.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:
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 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 (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 _____
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 _____ -OR- PIN Location ID _____ -OR- 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 _____
Facility Phone Number _____ Facility Fax Number _____

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