inSupport™

PO Box 29297 | Phoenix, AZ 85038
Phone: 844-INSPPRT (844-467-7778)
Fax: 844-814-0669
www.insupport.com

PATIENT ENROLLMENT FORM

TO ENROLL WITH INSUPPORT™

1. Review descriptions of the 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 to INSUPPORT at 844-814-0669.

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 PROGRAM OPTIONS

Benefit Coverage Information

Obtain information about a patient's insurance coverage for SUBLOCADE™ (buprenorphine extended-release). 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 for the Copay Assistance Program for SUBLOCADE, or provide alternate funding information
- Required sections of the patient enrollment form: **Steps 1–8**

Pharmacy Routing and Status Information

When the specialty pharmacy path is chosen to acquire SUBLOCADE, INSUPPORT can route the patient's information to the specified specialty pharmacy and provide status information for the prescription throughout the pharmacy process.

- Required sections of the patient enrollment form: **Steps 1–6** and **Step 8**
- Please Note: If a commercial patient, you may also select the "Copay Assistance Program" option. See below

Copay Assistance Program for SUBLOCADE

Copay assistance is available for eligible privately insured patients to assist with the out-of-pocket cost of SUBLOCADE. Not all patients are eligible. Terms and Conditions apply.

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

Appeals Information

Obtain information about the appeals process for a patient's denied prior authorization (PA) or insurance claim.

- Please provide a copy of the denial correspondence from the patient's insurance provider for the denied PA or insurance claim
- For denied claim appeals, please also provide a copy of the original claim form(s) and the Explanation of Benefits from the patient's insurance provider
- Required sections of the patient enrollment form: **Steps 1–6** and **Step 8**

Alternate Funding Information

Obtain information about potential alternate funding sources for an uninsured or underinsured patient.

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

WARNING: RISK OF SERIOUS HARM OR DEATH WITH INTRAVENOUS ADMINISTRATION; SUBLOCADE RISK EVALUATION AND MITIGATION STRATEGY

- **Serious harm or death could result if administered intravenously. SUBLOCADE forms a solid mass upon contact with body fluids and may cause occlusion, local tissue damage, and thrombo-embolic events, including life threatening pulmonary emboli, if administered intravenously.**
- **Because of the risk of serious harm or death that could result from intravenous self-administration, SUBLOCADE is only available through a restricted program called the SUBLOCADE REMS Program. Healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified in this program and comply with the REMS requirements.**

Indivior Inc. reserves the right to cancel, revoke, or change the INSUPPORT program as they choose without prior notice.

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

Sublocade™
(buprenorphine extended-release) injection for subcutaneous use Ⓒ 100mg·300mg

inSupport™

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STEP 1 Program Options

Benefit Coverage Information | Pharmacy Routing and Status Information | Copay Assistance Program | Appeals Information | Alternate Funding Information

Specialty Pharmacy (required)

STEP 2 Provider Information (To be completed by the provider only)

First Name | Last Name

NPI # | State License # | DEA #

Facility Type: Private Practice | Residential Treatment Center | Outpatient Hospital/Clinic | Other

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

Practice Address | City | State | ZIP

( ) Practice Phone Number | ( ) Practice Fax Number

Practice Contact First and Last Name | ( ) Practice Contact Phone Number

Preferred Product Acquisition (Required only if "Benefit Coverage Information" option is requested in **Step 1** above):

Specialty Distributor—Buy-and-Bill | Specialty Pharmacy | Preferred Specialty Pharmacy: ____________

(Used if specialty pharmacy is not payer-mandated)

STEP 3 Treatment Information (To be completed by the provider only)

ICD-10 Diagnosis Code: ____________ Scheduled Injection Date: __/__/____(if known)

Prescribed Dose: SUBLOCADE™ 300 mg | SUBLOCADE™ 100 mg

***Reminder: If using a specialty pharmacy, please remember to send a valid prescription for SUBLOCADE directly to the pharmacy.**

STEP 4 Provider Attestation

By signing below, I certify the following:

1) The information inserted in Steps 2, 3, 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 (i) participate in the INSUPPORT program; and (ii) 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) and the Confidentiality of Substance Use Disorder Patient Records Regulation (codified at 42 C.F.R. Part 2), as amended from time to time; 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) I am willing to have INSUPPORT contact me for additional information relating to the INSUPPORT program, including via email, fax, telephone, or other means; 6) 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; 7) I agree that in no event shall Indivior be liable for any damages resulting from or relating to requested or provided information from INSUPPORT; 8) I understand that I may be invited to participate in optional surveys regarding education and patient treatment; 9) I understand that Indivior Inc. reserves the right, at any time and without notice, to rescind, revoke, or amend the INSUPPORT program.

By siging below, I confirm that I have read, understand, and agree to the Provider Certification and Terms and Conditions for the INSUPPORT™ Copay Assistance Program, as applicable, as well as this Provider Attestation.

X ____________ Provider Signature | __/__/____ Date

Please see accompanying Full Prescribing Information, including **BOXED WARNING**, and Medication Guide or go to SUBLOCADE.com. For REMS information visit www.sublocadeREMS.com.

Sublocade™ (buprenorphine extended-release) injection for subcutaneous use Ⓒ 100mg·300mg

The INSUPPORT™ Copay Assistance Program for SUBLOCADE™ (buprenorphine extended-release) Terms and Conditions

To receive benefits under the INSUPPORT Copay Assistance Program, the patient must be determined as eligible and be enrolled in the Copay Assistance Program.

Patient Eligibility Requirements:

- Patient must have private health insurance that provides coverage for some portion of the cost of SUBLOCADE under a medical or pharmacy benefit plan. The Copay Assistance Program is not valid for uninsured patients.
- 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.
- Patient is at least 18 years of age and less than 65 years of age.
- The Copay Assistance Program is available to patients only for "on-label" use.
- Patient is a resident of the United States or U.S. 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 SUBLOCADE.
- The INSUPPORT Copay Assistance Program is not insurance.

Program Enrollment:

- Patient's provider must request eligibility determination and enrollment for the Copay Assistance Program on behalf of the patient via the INSUPPORT Patient Enrollment Form or the INSUPPORTTM Copay Assistance Portal located at www.insupportcopay.com.
- 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 enroll an eligible 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.
  - Applicable to only one practice and affiliated provider(s). Should the patient change to a provider belonging to a different practice, the patient's eligibility to receive benefits under the Copay Assistance Program will not be impacted, however the patient and the new provider must complete the required information on the Enrollment Form before the Program benefit for which the patient is eligible can be paid to such provider on the patient's behalf.
- The eligibility period for the 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.
  - Eligible patients may receive benefits for valid claims submitted with a date of service that is up to 90 days prior to the initial enrollment date, and up to 30 days prior to the re-enrollment date.

Program Benefit and Conditions:

- Eligible patients may pay as little as $5 per injection of SUBLOCADE throughout the eligibility period.
- Following the patient's initial enrollment in the Program, and each subsequent calendar year the patient remains on SUBLOCADE and continues to meet the Program eligibility criteria, the patient will receive the following medication copay assistance:
  - The patient will receive an expanded benefit amount for the first two injections in the calendar year. The expanded benefit amount is up to $1,659 for SUBLOCADE.
  - Following the first two injections of SUBLOCADE in the same calendar year, the patient will receive a maximum copay assistance amount of $800 per injection for the remainder of the calendar year.
  - If patient's financial responsibility for the medication is greater than the maximum benefit per injection, the patient will be responsible for any remaining costs not covered by the copay assistance benefit dollars.
  - Expanded benefit resets at beginning of each calendar year.
- The Program benefit may be applied for maximum of 14 injections per calendar year and requires that there must be a minimum of 23 days between dates of service. The maximum possible annual benefit is $12,918.
- If SUBLOCADE is covered under the patient's medical benefit plan:
  - An Explanation of Benefits (EOB) from 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 SUBLOCADE and submission of the claim by the patient's provider for the cost of SUBLOCADE.
- The benefit available under the Copay Assistance Program is valid for the patient's out-of-pocket cost for SUBLOCADE 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 the SUBLOCADE. Claims for SUBLOCADE must be submitted by the provider to patient's private health insurance separately from other services and products.
- Copay claims will be processed, and benefits applied, in the order in which they are received.
- Patient and provider agree not to seek reimbursement from any insurer or payor for any or all of the benefit received by the patient through the Copay Assistance Program.
- The Copay Assistance Program benefit is non-transferable, limited to one person, and cannot be combined with any other Copay Assistance Program, free trial, discount, prescription savings card, or other offer. Offer has no cash value.
- 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 Copay Assistance Program.
- Indivior Inc. reserves the right to rescind, revoke, or amend the INSUPPORT Copay Assistance Program at any time without notice.

Provider Certification: The INSUPPORT™ Copay Assistance Program

By signing above, I certify that:

1) I have prescribed the Program Product to the patient identified in the Patient Contact Information section of this Form (the "Patient") in the exercise of my independent medical judgment for its FDA-approved indication; 2) I have read the Terms and Condition of the INSUPPORT™ Copay Assistance Program and, to the best of knowledge, the patients meets the criteria set forth in the Terms and Conditions; 3) I/my office will not seek reimbursement for any offering or benefit provided by or through INSUPPORT from any government program or third-party insurer; 4) I/my office will not take into account the fact that the patient may receive a benefit from the Copay Assistance Program when determining the amount of any charge(s) to the patients; 5) I/my office will not charge the patient any fee to complete this form and I/my office will not advertise or otherwise use the Copay Assistance Program as a means of promoting my services or the Program Product; 6) The claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient; 7) I am/my office is responsible for reporting receipt of Copay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Copay Assistance Program, as may be required; 8) If the Patient's benefit received under the Copay Assistance Program will be paid directly to me/my office by the Copay Assistance Program on behalf of my Patient, I/my office will apply any amounts received from the Copay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my office already received payment from the Patient for the Patient's share of the cost of the Program Product for which the Patient receives a benefit through the Copay Assistance Program, I/my office will refund the amount received back to the Patient; 9) I may be asked to sign a new Provider Certification if the Terms and Conditions of the Copay Assistance Program for the Program Product change.

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 and that I meet the Program's eligibility requirements, to include the following:

1) I have private health insurance which covers some portion of my prescribed medication; 2) 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 Medicaid, Medicare, TRICARE, Department of Defense, or Veterans Administration, etc.; 3) I will not seek reimbursement for the cost of my prescribed medication (in full or in part) from any third-party payers, including a flexible spending or healthcare savings account; 4) I will notify INSUPPORT immediately if I change providers, if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer.

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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 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 list below.

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 for Alternate Funding Information)

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 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 and any affiliated group practices), 2. The health insurer(s) listed on my enrollment form, and 3. The specialty pharmacy to which my SUBLOCADE prescription is sent for fulfillment **to use and to disclose** to Indivior Inc. (including any of its affiliates), INSUPPORT, McKesson Corporation and any of its affiliates including RxCrossroads by McKesson, SourceHOV L.L.C., NDC Health Corporation d/b/a/ RelayHealth, Capgemini America, Inc., Symphony Health Solutions, Corporation (including its affiliate Source Healthcare Analytics, L.L.C.), AmerisourceBergen Corporation (including its affiliate Xcenda L.L.C.), and my Authorized Representative (if named) (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 SUBLOCADE. 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 SUBLOCADE; d) coordinate and route information among Recipients to help in the coordination of my treatment with SUBLOCADE; 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 SUBLOCADE. I understand that my specialty pharmacy may receive payment from Indivior Inc. in exchange for providing my Information per this authorization.

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 participate in the INSUPPORT program. This authorization does not permit the recipient of my mental health and drug treatment Information to further share the Information without my permission unless allowed under state and federal law. Any communication containing my mental health or drug treatment Information in reliance on this authorization must include a notice that such Information may not be shared further. Other 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, 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.

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100mg·300mg

inSupport™

Provider Name: ____________

Fax INSUPPORT: 844-814-0669

STEP 8 Patient Authorization for Use and Disclosure of Health and Personal Information (Cont.)

Additional Options – check the box to opt-in (Optional)

I also authorize McKesson Corporation and its affiliates to disclose my Information to Klick Health so it may send me educational materials, via email or US mail, related to my treatment with SUBLOCADE, or other related Indivior products and services.

Only applicable if "Benefit Coverage Information" is requested on this enrollment form:

I authorize INSUPPORT to use my Information so I may receive a phone call or voicemail, at the number provided below, for the purpose of INSUPPORT to review my benefit coverage information for SUBLOCADE with me.

Preferred Phone Number: (   ) ____________

Best Time to Call: Morning Afternoon Evening

I authorize INSUPPORT to use my Information to provide me a copy of my benefit coverage information for SUBLOCADE.

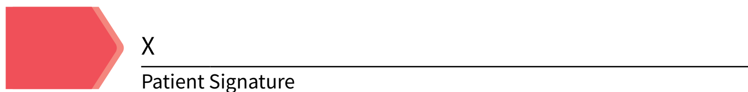
Authorized Representative (Optional)

Authorized Representative/Guardian Name (please print) ____________ Relationship to Patient ____________ Phone Number (   ) ____________

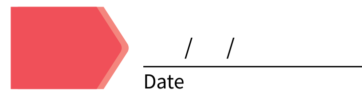
Patient Signature and Date Required

By signing below, I confirm that I have read, understand, and agree to this Patient Authorization.

Patient Name (please print) ____________



X ____________ Patient Signature



/ / ____________ Date

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