



### SECTION 3 Patient Insurance Information

Check here if submitting a copy of the patient's medical and pharmacy insurance card(s) with the enrollment form (attach a copy of both sides).

Continue completing this section ONLY if not submitting a copy of the patient's insurance card(s).

Private/Commercial    Medicaid – State: \_\_\_\_\_    Medicare    Other    Uninsured

Primary Insurance Type \_\_\_\_\_ Primary Insurance Name \_\_\_\_\_

Beneficiary/Cardholder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_ Primary Insurance Phone Number ( ) \_\_\_\_\_

If the patient has a separate prescription coverage plan, please add below (for 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 ( ) \_\_\_\_\_

### SECTION 4 Provider Information

\*Provider First Name \_\_\_\_\_ \*Provider Last Name \_\_\_\_\_ \*Provider NPI # \_\_\_\_\_

Private Practice    Outpatient Hospital/Clinic    Inpatient Hospital    Residential Treatment Facility

\*Facility Type \_\_\_\_\_ \*Practice/Facility Name \_\_\_\_\_

\*Practice/Facility Address \_\_\_\_\_ \*City \_\_\_\_\_ \*State \_\_\_\_\_ \*ZIP \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ Practice/Facility Contact First and Last Name \_\_\_\_\_ Practice/Facility Contact Phone Number ( ) \_\_\_\_\_

\*Practice/Facility Phone Number \_\_\_\_\_ \*Practice/Facility Fax Number \_\_\_\_\_

Provider Email \_\_\_\_\_ Send all communications via email \_\_\_\_\_ \*Provider Tax ID# \_\_\_\_\_ Practice NPI # \_\_\_\_\_

### SECTION 5 Treatment Information

\*ICD-10 Diagnosis Code: \_\_\_\_\_ Next Injection Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Prescribed Dose (check one only):    SUBLOCADE 300 mg    SUBLOCADE 100 mg

For a list of ICD-10 codes that may be used for appropriate SUBLOCADE® (buprenorphine extended-release) patients, please see the Billing and Coding Guide <https://insupport.com/billing>

Check here to verify payer coverage for a second SUBLOCADE dose as early as 1 week following the initial administration. Do not check the box if second dose will occur 1 month after first dose.

Days supply written on first fill: \_\_\_\_\_

The first-fill days supply should reflect that the accelerated second dose of 300 mg SUBLOCADE injection can be given as early as day 8 and up to 1 month after the first dose.

### SECTION 6 Additional Program Options

#### Copay Assistance Program (for eligible patients)

Commercially insured patients who are eligible to receive copay assistance will automatically be enrolled by INSUPPORT. You will receive their copay card details in the benefit summary.



For INSUPPORT Copay Assistance Program full terms and conditions, visit <https://www.insupport.com/pdf/copay-assistance-terms-and-conditions.pdf>

INSUPPORT offers a Copay Assistance Program to help eligible patients with the out-of-pocket costs for SUBLOCADE. **Eligible commercial insurance patients will be automatically enrolled into the Copay Assistance Program.** Copay Card IDs will be included in the benefit summary.

**SECTION 6 Additional Program Options (cont.)**

**For Medicaid patients only.** Check here for INSUPPORT to verify that patients insurance provides additional coverage for transportation.

**Community Reentry Program (for eligible patients)** Check the box to opt in

Provides up to 2 months of product at no cost to enrolled patients, who are transitioning from a criminal justice facility, while they obtain insurance coverage. For full terms and conditions, please see Section 8. **To enroll the patient in the Community Reentry Program, Sections 2-8 must be completed.**

By checking the box above, I certify that I have read, understand, and agree to the terms and conditions of the Community Reentry Program and that I meet the Program’s eligibility requirements that include, but are not limited to, the following:

- The Community Reentry Program is available to patients for “on-label” use.
- Patient has applied for insurance coverage and is pending payer enrollment decision.
- Patient is a resident of the United States or U.S. territories.
- Patient is currently taking or was previously prescribed SUBLOCADE® (buprenorphine extended-release) by a treatment provider.
- Patient has been given a certain release date or has been recently released from the criminal justice system.

**Next Steps**

1. Fax prescription to AllCare Plus Pharmacy at 844-740-1211, or
2. ePrescribe through the eRx platform to AllCare Plus Pharmacy, 50 Bearfoot Rd., Northborough, MA 01532-1514, **NPI 1902167596**
3. SUBLOCADE will be shipped and confirmed from AllCare Plus Pharmacy to the healthcare provider.

**Provider signature required below to enroll patient in the Community Reentry Program.**

**Community Reentry Program Terms and Conditions**

By checking the box above, I, the Provider, agree to the terms and conditions and certify that the information provided is accurate. The Community Reentry Program provides transition of care for an eligible patient prescribed SUBLOCADE who is transitioning from a criminal justice facility to the community without access to health insurance upon release. The Community Reentry Program provides up to 2 months of product at no cost to enrolled patients while they obtain insurance coverage for SUBLOCADE. Patients must be currently receiving SUBLOCADE therapy and experiencing a gap in insurance coverage. Patients who have not yet received their first dose of SUBLOCADE are not eligible. Product provided through the Community Reentry Program at no charge is only available through a Community Reentry Program contracted pharmacy (INSUPPORT Network specialty pharmacy). Eligibility will be determined based on the Community Reentry Program eligibility requirements. Indivior reserves the right to change or end the Community Reentry Program at any time, and other terms and conditions may apply.

**SECTION 7 Provider Attestation**

**Provider Signature and Date Required**

By signing below, I certify the following: 1) The information inserted in this Enrollment Form has been provided exclusively by me (the provider named in this Form) or my office or my facility (“my Practice or Facility”) and that information is accurate to the best of my knowledge; 2) Based solely on my professional judgment 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 or Facility 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) 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 using my Practice/Facility Contact information provided in this Form; 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 signing below, I confirm that I have read, understand, and agree to the Provider Attestation.**

\*Provider Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

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

**SECTION 8 Patient Authorization for Use and Disclosure of Health and Personal Information**

**Patient Signature and Date Required**

By signing below, **I authorize** (1) My treatment provider (including 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 specialty pharmacy to which my SUBLOCADE® (buprenorphine extended-release) prescription is sent for fulfillment to use and to 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, but not limited to, any information about me on this enrollment form and/or about my medical treatment with SUBLOCADE, for purposes of facilitating my enrollment in and participation in the INSUPPORT program. I further authorize the Recipients to share my Information among themselves, so that one or more of them can: a) administer and/or provide INSUPPORT program services or information related to my enrollment; b) conduct an insurance benefit verification and communicate my health insurance company’s requirements for access to treatment with SUBLOCADE; c) coordinate and route information among Recipients to help in the coordination of my treatment with SUBLOCADE; d) provide me with educational or support services by mail, email, and/or telephone, which may include sending me product and/or treatment information; e) invite me to participate in optional surveys about my treatment, and/or; f) 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 and the Community Reentry Program. I understand that my specialty pharmacy may receive payment from Indivior Inc. in exchange for providing my Information per this authorization. I consent to INSUPPORT using my information to send me text messages, at the cell phone number I have provided on this Enrollment Form. I acknowledge that standard text message rates apply and that I can reply STOP at any time to cancel text messaging from INSUPPORT.

**Signing this form is my choice.** I understand that I do not need to sign this form in order to obtain treatment, insurance, or insurance benefits; I am required to sign it only if I wish to participate in the INSUPPORT program. Any communication conveying my mental health or drug treatment Information in reliance on this authorization must include a notice that such Information may not be shared further. I understand that my Information shared in reliance on this authorization might, once shared, no longer be subject to federal or state privacy laws and could be shared further.

**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 IQVIA, 430 Mountain Avenue, Suite 105, New Providence, NJ 07974. I understand that such a revocation will not apply to uses or disclosures made before INSUPPORT receives my statement of revocation. If I do not revoke the authorization, it will expire five (5) years from the date I sign below, or upon such earlier date as may be mandated by state law. I have the right to receive a copy of this authorization after I sign it. I understand that I may refuse to sign this authorization and that refusing to sign this authorization will not change the way my physician, health insurance, and pharmacy providers treat me.

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

 \*Patient Name (please print): \_\_\_\_\_

 \*Patient Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

**For additional information, reach out to INSUPPORT.**

**Call: 844-INSPPRT (844-467-7778)**

**Email: enroll@insupport.com**