

PROBUPHINE® (buprenorphine) Implant

PATIENT ENROLLMENT FORM

Fax completed form to 1-877-805-7373

No P.O. Box Please complete all fields to avoid delays

Titan Access Program

Monday – Friday 8am – 7pm CT

Phone: 1-844-859-6341



PATIENT INFORMATION

First Name: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Male Female

Please mark preferred phone for contact

Phone: Cell _____ Home _____ Work _____

Email Address: _____

By signing, I have read and agree to the **PRIVACY NOTICE, PATIENT AUTHORIZATION & MARKETING CONSENT** see (Section A) attached.

X _____
Patient Signature (or Legal Representative Signature) Date

Legal Representative Name: _____

Legal Rep Phone: _____ Relationship: _____

PRIMARY INSURANCE

Attach FRONT and BACK copy of ALL insurance cards (Prescription and Medical)

Insurance Name: _____

Policyholder Name: _____

Policy #: _____ Insurance Phone: _____

Group #: _____ Policyholder Relationship: _____

PBM Insurance Name: _____ ID#: _____

- Patient uninsured
- Has secondary insurance

Initial Here

(Optional)
I want to participate in the **Titan Access Program CoPay Assistance Program** see (Section B) attached.

NOTE: Patients insured with federal health care program Such as Medicare, Medicaid, VA, Tricare, etc. will not be eligible.

Household size: _____ Household income: _____/month

FOR OFFICE USE ONLY

PRESCRIBER \ IMPLANTER INFORMATION

Prescriber First Name: _____ Last: _____

Primary Specialty: _____ NP PA

NPI #: _____ Group NPI #: _____

Practice Name: _____

Practice Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

State License #: _____ Tax ID #: _____

DEA #: _____ XDEA #: _____

Office Contact Name: _____ Phone: _____

Site of service: Physician Office HOPD ASC

Implanter Information: Check if same as Prescriber Information

Implanter/Remover First Name: _____ Last: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI #: _____ Group NPI#: _____

Tax ID #: _____

SHIP TO: Office Other facility

SHIP TO (if not Office) DEA # (required): _____

SHIP TO Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____

PRESCRIBER DECLARATION

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed Probuphine based on my judgement of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Titan Pharmaceuticals, and parties working with Titan Pharmaceuticals to perform a preliminary assessment of insurance verification and determine patient eligibility for the Titan Access Program. I authorize the forwarding of this prescription to a REMS-certified pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program or counted toward Medicare Part D out-of-pocket costs.

Prescriber Signature: _____

Date: _____

(NO STAMPS)

No guarantee Probuphine will be approved by patient's health plan

TITAN ACCESS PROGRAM Phone: 1-844-859-6341

Titan has programs to support patients and providers, and we will use the information provided to see which program, based on the programs criteria, patients qualify for.

Please read the following statements carefully, then sign and date where indicated on the previous page.

A. PRIVACY NOTICE, PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & MARKETING CONSENT

By signing this Authorization on the accompanying form, I hereby authorize my doctor(s) and their staff, my health insurer(s) and the specialty pharmacy or distributor that will supply PROBUPHINE and/or fill my prescription (the "Pharmacy") to disclose my personal information, including but not limited to, information about my medical condition and treatment (including prescriptions), health insurance, social security number and related information ("Personal Information") to Titan Pharmaceuticals, its business partners and agents, including the Pharmacy (together "Titan Pharmaceuticals"), to help implement the Titan Access Program described to me by my doctor (the "Program"). I understand that my Personal Information will be used by Titan Pharmaceuticals to (i) help verify, investigate or coordinate insurance coverage and payment for PROBUPHINE; (ii) coordinate my receipt of, and payment for PROBUPHINE; (iii) enroll me in and contact me about the Program; (iv) provide education, information, products, programs and services; (v) permit Titan Pharmaceuticals to manage the Program, and conduct marketing analyses or other commercial activity, including aggregating my Personal Information with other data; and (vi) assist with analyses related to quality, efficacy and safety for PROBUPHINE. I understand that Titan Pharmaceuticals, through the Program or the Pharmacy, may report back to my doctor(s) any Personal Information about me that they may create or receive. I agree that Titan Pharmaceuticals may contact me in the future via email, mail, phone or otherwise. I understand that some pharmacies may receive payment for disclosing my Personal Information and in exchange for providing the services associated with the program. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and it may be subject to re-disclosure without my permission; however, Titan Pharmaceuticals agrees to use and disclose my Personal Information only for the purposes described in this Authorization or as required by law. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect my treatment, payment or eligibility for benefits. Revoking this authorization will not affect Titan Pharmaceuticals' ability to use and disclose Personal Information it has already received. This authorization will remain valid for ten (10) years after the date of my signature, unless I revoke it earlier by calling 1-844-859-6341 or by writing to: Titan Access Program, 6330 West Loop South, 7th Floor, Bellaire, TX, 77401. I also understand that the Program may be changed or ended at any time without prior notification and that I will receive a copy of this authorization.

B. COPAY ASSISTANCE PROGRAM

<p>HAVE A QUESTION? Call Titan Access Program at 1-844-859-6341 Monday - Friday, 8 AM - 7 PM CT</p>	<p>If you have not received an update by _____ (date) Please dial 1-844-859-6341</p>
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