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 – 6pm 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: ___________________

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***

DIAGNOSIS

DIAGNOSIS/CLINICAL INFORMATION - *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

ICD-10 code(s): ☐ F11.XX. ____________________ ☐ CPT Code(s): ____________________ ☐ Other(s): ____________________

☐ NKDA ☐ Known drug allergies:____

Concurrent Medications:____

PRESCRIPTION

PROBUPHINE (buprenorphine) Implant PRESCRIPTION

Please complete as follows: **Medication:** Probuphine (buprenorphine) implant; **Dose/Strength:** 74.2 mg x 4 implants; **SIG:** insert 4 implants subdermally; **Quantity:** 1 kit

Medication	Dose/Strength	SIG	Quantity

- Prescription use of this product is limited to prescribers who are authorized to treat opioid dependence and are DATA 2000-waivered, and REMS-certified.
- Probuphine® may only be delivered to a healthcare setting, and is NEVER dispensed to a patient directly.
- Probuphine can only be obtained through REMS-certified pharmacies; please visit www.ProbuphineREMS.com for more information.

______________________________ ______________________________ OR ______________________________

Prescriber Name ***(Print)*** *Date* *Prescriber Signature Dispense as Written (DAW)* ***(NO STAMPS)*** ***Prescriber Signature*** *Substitutions Allowed* ***(NO STAMPS)***

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

PHYSICIAN ATTESTATION

PRESCRIBER ATTESTATION FOR PATIENT COPAY ASSISTANCE PROGRAM

Patient has been in compliance with my clinical guidance for the past 6 months: ☐ YES ☐ NO

It is my opinion that the above referenced patient requires additional copay support: ☐ YES ☐ NO

When you use this program, you are attesting that you have not submitted and will not submit a claim for reimbursement under any federal health care program for this prescription. You understand that you are responsible for disclosing to insurance carriers or third-party payers the use and value of this program, if required, and complying with any other conditions or requirements by insurance carriers or any third-party payers. This program is not available for prescriptions for which payment may be made in whole or in part under Federal or State health care programs, including but not limited to Medicare or Medicaid. This program does not apply to the implant procedure and is subject to termination or modification at any time. This program does not create any obligation or is not based on any past or future purchase requirement.

BUY & BILL ORDER

Probuphine Qty: _______________ kit(s)

Ship prior to coverage confirmation?

☐ YES ☐ NO

Tax Exempt?

☐ YES ☐ NO

Exempt ID: _______________

Ancillary Products:

Insertion Kit Qty: _______________

Removal Kit Qty: _______________

The document (s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug Treatment-Related Information: To the extent that drug treatment-related information has been provided to you, such information has been disclosed to you from records whose confidentiality may be protected by federal and state law. Such laws may prohibit you from making any further disclosure of the drug treatment-related information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said laws.

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 1-844-859-6341or 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

HAVE A QUESTION? Call Titan Access Program at 1-844-859-6341 Monday - Friday, 8 AM - 6 PM CT	If you have not received an update by _________________________(date) Please dial 1-844-859-6341