Titan Patient Assistance Program Application

Phone: 1-844-859-6341
Fax: 1-877-805-7373

The Titan Patient Assistance Program provides Probuphine at no cost to patients that do not have healthcare coverage and/or adequate coverage for Probuphine. All applications are reviewed on a case-by-case basis to support the Titan Assistance Program's purpose of providing products at no cost to individuals in need.

Checklist for submitting an application:

Ensure all sections of the application are completed.

- ☐ Attach any of these items as current proof of income: tax return (such as a W2, 1040, 1040A, 1040EZ), last two recent pay stubs, Social Security Retirement and Supplemental Social Security, proof of unemployment compensation, benefit statement for disability, pension, retirement, veteran's benefits, signed notarized statement explaining the patient's financial situation).
- ☐ Patient's signature/date is required on the application
- ☐ Prescriber's signature/date is required on the application
- ☐ Provide a copy of Patient's Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax the completed application and documentation to:

Titan Patient Assistance Program
Phone: 844-859-6341
Fax: 877-805-7373

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility in writing. If the patient is approved for assistance, the product will be shipped to the prescriber's office.

Please contact us at 1-844-859-6341, Monday – Friday 8am – 7pm CST for additional assistance.

Please complete the form and make a copy before sending as no documents will be returned. Prescriber's signature/date is required on the application.

Please click here for Full Prescribing Information, including Boxed Warning and Important Safety Information.

Probuphine® (buprenorphine) implant

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TITAN PHARMACEUTICALS

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Patient Name: _____
First Last

Patient Address: _____
Street City State Zip code

Patient Telephone Number: _____

Patient Date of Birth: _____
(mm/dd/yyyy)

Case ID (if any): _____

Information required for additional need based assistance:

Patient's monthly household income: ☐

Are you enrolled in Medicare? Yes ☐ No ☐

If yes, check all that apply: Part A ☐ Part B ☐

Part D - Do you have private medical insurance? Yes ☐ No ☐

Are you covered through a Medicaid Program? Yes ☐ No ☐

Number of people in your household (including yourself) ☐

Number in household under 18 years of age ☐

Important Information about the Titan Patient Assistance Program

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the Titan Patient Assistance Program. In the event that I am eligible for the Program's assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Program. I also understand that the Program assistance may change or be discontinued at any time without any notice to me. I agree that I will not seek reimbursement for any Probuphine dispensed under the Program from any third-party payer, including any government program (such as Medicare or Medicaid) or any private or other insurance plan. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive Probuphine from the Program. I agree that I will notify the Program if my insurance or financial situation changes.

The Program will use my information for purposes of determining patient assistance eligibility. I understand that I need to give my authorization to take part in the Patient Assistance Program ("PAP") should I quality. I know I may cancel this authorization at any time by writing to the Titan Patient Assistance Program at 6330 West Loop South, 7th Floor, Bellaire, Texas 77401 . If I cancel this Authorization, I can no longer participate in the PAP.

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This authorization shall be valid for 10 years from the date of the signature on this form. I authorize the Program to use my information: (i) to determine eligibility for PAP, (ii) to account for my withdrawal if I decide to stop participating in the PAP, (iii) to administer and maintain high quality service, and (iv) as otherwise required or permitted by law. I agree that the Program does not have any liability in providing PAP services to me.

Patient Consent/ Authorization to Disclose Health Information

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 Patient Assistance Program. 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, telephone or otherwise. 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. 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.

Patient's Signature:_____

Date:_____

Representative For Purposes of Program (If applicable)
I permit the Titan Patient Assistance Program to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name:_____**Relationship:**_____**Phone:**_____

Personal Representative Authorization (if applicable)
Note: If the Applicant is unable to sign has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant's financial and health care status to verify that all

responses provided are accurate. State law may prescribe who can be a Personal Representative for purposes of this Authorization. A person or entity in the supply chain of the product to be received through the Program, including a health care provider or pharmacy receiving the product at no cost, may not be need a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature:_____**Relationship:**_____**Date:**_____

Medicine Requested

Probuphine Kit ☐

Prescriber Information:

Prescriber First Name:_____**Last:**_____

DEA#:_____**SLN # and Expiration Date**:_____

Prescriber Shipping Address:_____

Office Contact:_____ **Telephone:**_____**Fax #:**_____

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 ☐

Authorization for Release of health Information: by signing this form, I represent to the Titan Patient Assistance Program that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to the Titan Patient Assistance Program and its contracted third parties.

Physician: I verify that the information provided is current, complete and accurate to the best of my knowledge and certify that I am authorized to receive medications at the shipping location identified in this application. I verify that my State License and DEA # with DATA 2000 waiver is currently in good standing. I further certify that I will notify the Titan Patient Assistance Program (the "Program") in writing immediately if the status of my State License Number registration changes.

I agree that Probuphine provided by the Program is to be used solely for administration to this patient and for no other purpose. Neither you, your institution, nor any other person, including the patient, may seek payment or accept reimbursement from any third party payer, including any federal health care program such as Medicare or Medicaid, private or other insurance plan, or from any other person or entity for free Probuphine supplied under this Program. Further, you agree not to charge, or submit any claim for reimbursement for

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Probuphine to patient or any third-party payor, including any federal health care program such as Medicare or Medicaid. No product supplied under the Program may be sold, traded, or distributed for sale. Please check with your local Medicare contractor, your state Medicaid program, or the appropriate payer to confirm whether and how you should reflect the no-charge Probuphine dose on any claim submitted for the associated procedure.

I agree as the prescribing physician and/or implanter to provide my services at no cost to the patient. Finally, I agree to inform Titan of Serious Adverse Events (SAE's), whether the event is related to Probuphine or not. The Program reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature (no stamps):_____**Date:**_____

Notice to Health Care Providers and Insurers: this is form of authorization may not comply with all applicable Federal and state laws governing disclosure of the applicant's information to the Program and its contracted third parties. The Program urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.

Please see Full Prescribing Information, including Boxed Warning, for Important Safety Information.

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