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

TITAN PHARMACEUTICALS

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: _____

Legal Representative Email: _____

☐ Check box if OK to leave message with Legal Representative

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

If NP/PA, Name of Supervising Physician (***if applicable***): _____

Office/Clinic/Institution Name: _____

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 (*NOTE: Shipping Location must hold DEA registration*) 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 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***

PATIENT INFORMATION

First Name: _____ Last: _____

Date of Birth: _____

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.
- Prescriber is to comply with his/her state specific requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with states specific requirements could result in outreach to the prescriber.
- Probuphine® may only be delivered to a healthcare setting, and is NEVER dispensed to a patient directly.
- Once approved the prescription can be sent to the pharmacy as designated by the patient and/or their prescription benefit design.

_____ _____

*Prescriber Name **(Print)*** *Date*

_____ OR _____

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

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: _____

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 a shorter period is mandated by state law or 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 - 7 PM CT	If you have not received an update by _____(date) Please dial 1-844-859-6341