**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: ______________

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 am eligible to participate in the **Titan Access Program CoPay Assistance Program** see (Section B) attached.

_______ *Initial Here*

**Medicaid eligible patient**:
Patient Medicaid Identifier: ___________
Plan Name _______________________

**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 #: ____________________ PTAN #: _______________________

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***

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.

TTN-PRO-045-3-MAY20

**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 benefit investigation?

☐ YES ☐ NO

Tax Exempt (340B pricing)?

☐ YES ☐ NO

Exempt ID: ___________

Medicaid eligible?

☐ YES ☐ NO

Patient Plan ID: ________

Ancillary Products:

Insertion Kit Qty: _______

Removal Kit Qty: _______

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

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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

Patients insured with federal health care program such as Medicare, Medicaid, VA, Tricare, etc. are not eligible for copay assistance program.

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

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