Probuphine® (buprenorphine) implant

Braeburn® pharmaceuticals

P.O. Box 5038
Louisville, KY 40255
Phone: 1-844-859-6341
Fax: 1-866-441-4091

Braeburn Access Program™
Probuphine (buprenorphine) Implant
Patient Enrollment Form

Please complete all required fields on the form and fax to 1-866-441-4091or email info@braeburnaccessprogram.com for questions. Please confirm coverage prior to scheduling the procedure.

Please select the preferred method ☐ Specialty Pharmacy (SP) ☐ Consignment Program

Section 1: Patient Information

Patient Name (Last, First): _____
DOB (mm/dd/yyyy): _____ Male ☐ Female ☐
Home Phone: _____
Cell Phone: _____
Email Address : _____

Section 2: Insurance Information

Please include copy of card, front and back

Patient has medical Insurance Coverage: Yes ☐ No ☐
Primary Insurance Name: _____
Primary Insurance Phone: _____
Policy ID#: _____
Secondary Insurance Name: _____
Secondary Insurance Phone: _____
Policy ID#: _____

Section 3: 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 Braeburn Pharmaceuticals, its business partners and agents, including the Pharmacy (together "Braeburn Pharmaceuticals"), to help implement the Braeburn Access Program described to me by my doctor (the "Program"). I understand that my Personal Information will be used by Braeburn Pharmaceuticals to (i) help to 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 Braeburn Pharmaceuticals to manage the Program, and conduct market analyses or other commercial activity, including aggregating my Personal Information with other data; and (vi) assist with analysis related to quality, efficacy and safety for PROBUPHINE. I understand that Braeburn 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 Braeburn 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, Braeburn 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 Braeburn 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.

■ Check here if in addition to the above, you also authorize Specialty Pharmacy to dispense your Probuphine directly to your certified prescriber's facility, without obtaining any additional consent or providing any additional notice.

Patient/Guardian Signature: _____ **Date:** _____

Please see full Prescribing Information, including BOXED Warning.

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Section 4: Prescriber Information

Prescriber Name: _____ Practice Name: _____ Shipping Address*: _____

City/State/ZIP: _____ Phone: _____ Cell Phone: _____ Fax: _____

NPI: _____ DEA#: _____ **DEA# for Shipping Address:** _____

XDEA #: _____ Tax ID #: _____ SLN #: _____ PTAN# (only for Medicare): _____

Office Contact Name: _____ Office Contact Email: _____

Note: Probuphine orders cannot be processed unless the shipping address matches the address for the DEA Registration number provided on this form.

Section 5: Implanter Information

☐ *Check if same as Prescriber Information (Section 4).*

Name of Implanter/Remover (if different from Prescribing Physician): _____

Implanters Name (Last, First): _____ Implanter Address: _____

City/State/ZIP: _____ Phone: _____ Cell Phone: _____ Fax: _____

NPI #: _____ Group NPI #: _____ Tax ID #: _____

Section 6: Prescriber Billing Information

☐ *Check if information is same (Section 4).*

Practice Name: _____ Billing Address: _____

City/State/ZIP: _____ Phone: _____ Fax: _____

Billing Contact Name: _____ Billing Contact Email: _____

Section 7: Diagnosis/Clinical Information

PLEASE FAX 3 months of clinical notes, labs, and tests with prescription to expedite the Prior Authorization

ICD-10 Code(s): _____ CPT Code: _____ Buprenorphine daily dose: _____

Section 8: Prescription for Specialty Pharmacy Option

Please fill out the section below as follows: **Medication:** Probuphine (buprenorphine) Implant; **Dose/Strength:** 74.2mg x 4 implants; **SIG:** insert 4 implants sub-dermally; **Quantity:** 1 kit.

Medication	Dose/Strength

SIG	Quantity

Patient Name: _____

Patient Address: _____

Date: _____

Prescriber Name: _____

Prescriber Signature: _____
(NO STAMPS - HANDWRITTEN ONLY)

Dispense as Written: _____

Section 9: Consignment Program Option

Price per Probuphine® Kit $4,950.00

Ship product prior to coverage confirmation: Yes ☐ No ☐

Tax Exempt? Yes ☐ No ☐ Exempt ID: _____

Payment Terms for Consignment Program/Patient Self-Pay and Insertion and Removal: Payment may be made by check or money order net 90-days. Prohibition on Resale: Product may not be resold. Returns: Product is returnable only within 30 days of purchase (Return Goods Policy located on www.braeburnaccessprogram.com).

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Section 10: Insertion and Removal Kits

For consignment or SP, please determine if insertion or removal kits are needed and allocate the amount for each.

Insertion Kit

Desired Quantity: _____ Price Per Unit: $13.99

Removal Kit

Desired Quantity: _____ Price Per Unit: $29.91

Section 11: Prescriber Declaration and Business Associate Agreement

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™ (buprenorphine) implant based on my judgment 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 Braeburn, and parties working with Braeburn Pharmaceuticals, to perform a preliminary assessment of insurance verification and determine patient eligibility for the PROBUPHINE™ (buprenorphine) implant Program. I authorize the forwarding of this prescription to a dispensing entity 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.

I accept the terms of the attached Business Associate Addendum ("BAA") to allow RxCrossroads to use and disclose Protected Health Information on behalf of Prescriber ("PHI") to perform services, functions or activities on my behalf material term hereof.

Prescriber Signature: _____ **Date:** _____

BUSINESS ASSOCIATE ADDENDUM

Prescriber and RxCrossroads, Inc. ("RxCrossroads") enter into this Business Associate Addendum ("BAA") to allow RxCrossroads to use and disclose Protected Health Information ("PHI") on behalf of Prescriber to perform services, functions or activities for Prescriber, including but not limited to benefits verification and care coordination as set forth in the attached program services agreement (the "Agreement").
The following terms used in this Addendum shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

RxCrossroads agrees to:

(a) Not use and disclose PHI other than as permitted or required by the Agreement or required by law including for its own proper management and administration and to carry out its legal responsibilities subject to 45 CFR 164.504(e)(4), and to de-identify it, which de-identified information may be used and disclosed as permitted by law.
(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR 164 with respect to electronic PHI, to prevent unauthorized use or disclosure of PHI.
(c) Report to Prescriber any use or disclosure not provided for herein of which it becomes aware upon request, including Breaches as and when required by 45 CFR §164.410 or any Security Incident.
(d) Ensure that any Subcontractors that have access PHI on its behalf agree to the same restrictions and conditions as provided herein.
(e) Upon Prescriber's request, make available PHI and incorporate any amendment to PHI in accordance with 45 CFR §164.524 and §164.526 respectively, and make available the information required to provide an accounting of disclosures in accordance with §164.528.
(f) To the extent RxCrossroads carries out Prescriber's obligations under 45 CFR 164, Subpart E ("Privacy Rule"), comply with the requirements of the Privacy Rule that apply to Prescriber in the performance of such obligations.
(g) RxCrossroads agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary upon request for purposes of determining Prescriber's compliance with the Privacy and Security Rules.
(h) At termination of the Agreement, if feasible, RxCrossroads will return or destroy all PHI created or received on behalf of Prescriber and retain no copies or, if such return or destruction is not feasible, RxCrossroads will extend the protections of this BAA to such PHI and limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Prescriber may terminate the Agreement and this BAA if RxCrossroads violates a material term of the BAA and fails to cure within fifteen days of being provided notice of such breach by Prescriber.

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Probuphine Co-Pay/Co-Insurance Assistance

Braeburn offers co-insurance and co-pay support to assist patients with their out of pocket costs of Probuphine. Patients who would like to enroll must do so no later than 30 days post receipt of the Summary of Benefits in order to qualify. Probuphine Co-Pay Assistance is only applicable for the product Probuphine. The cost associated with the implantation or removal of Probuphine is not eligible for Co-Pay Assistance. A Patient, who is insured under a federal health care program such as Medicare, Medicaid, Veterans Affairs, Department of Defense, Tricare, etc., will not be considered eligible. Braeburn may terminate this program at any time.

Patient Information:

Name (Last, First): _____ DOB (mm/dd/yyyy): _____ Case ID (if any): _____

Type of Insurance (please check the applicable box):

☐ Medicare, Part A, B or D ☐ Medicare Advantage ☐ Medicaid ☐ Medigap ☐ Tricare ☐ DOD ☐ Veteran's Administration ☐ Commercial

Optional Information required for additional need based assistance:

Number of individuals in Patient's household (including Patient, other adults and children): _____

Household Annual Income: _____

Please attach to this form a signed statement explaining the patient's financial situation and proof of US residency such a bill with address or lease copy

Patient Signature: _____ **Date:** _____

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 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. Please also note that 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. Finally, please understand that use of this CoPay Program does not create any obligation or is not based on any past or future purchase requirement.

For Consignment Program Only. Please attach to this form the following documents:

- Provider's W9
- Payer's Explanation of Benefits

Physician Signature: _____ **Date:** _____

Please see full Prescribing Information, including BOXED Warning.