Probuphine® (buprenorphine) implant
PATIENT ENROLLMENT FORM
Fax completed form to 1-866-441-4091
No P.O. Box. Please complete all fields to avoid delays

Titan Access Program
Monday - Friday 8am - 8pm ET
Phone. 1-866-3S7-8939

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: _____

I have read and agree to the **PRIVACY NOTICE & PATIENT AUTHORIZATION,** attached.

X _____
Patient Signature *Date*
(or Legal Representative Signature)

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 Number: _____ ID#: _____

☐ Patient uninsured

☐ Has secondary insurance

_____ Initial Here

(Optional)
I want to participate in the **Titan Access Program CoPay Assistance Program**

Household size: _____ Household Income: $____/month
Patients eligible for up to 30% CoPay Support

FOR OFFICE USE ONLY

PRESCRIBER INFORMATION

Prescriber First Name: _____ Last: _____
Primary Speciality: _____ ☐ NP ☐ PA
NPI #: _____ Group NPI #: _____
Practice Name: _____
Practice Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
State License #: _____ Tax ID #: _____
Office Contact Name: _____ Phone: _____
XDEA #: _____ 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 enrolment 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 panent. I understand that neither I nor the patient should see reimbursement for any free product received under the program.

Prescriber Signature: _____ Date: _____
{Dispense as written. **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._____ ☐ 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 sub dermally; **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 lie obtained through REMS-certified pharmacies; please visit www.ProbuphineREMS.com for more Information.

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 AND 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: _____

TO BE PROVIDED TO THE PATIENT ~~FOR ENROLLMENT IN THE TITAN ACCESS PROGRAM~~

PRIVACY NOTICE & PATIENT AUTHORIZATION

By signing this Authorization on the accompanying form, I hereby authorize Titan Pharmaceuticals, Inc., and companies and parties working with Titan Pharmaceuticals, Inc., (collectively "Titan"), to use and/or disclose my health information about my medical condition, records, treatment, and health plan for the purposes stated below. I also authorize my healthcare providers, my health plans, and my pharmacies to disclose my health information to Titan for the purposes stated below. I understand this Authorization is voluntary, but Titan cannot provide me services and information without it.

Titan Access Program is a program sponsored by Titan that provides patient support and helps eligible patients access, afford, be informed about, and comply with their treatment as prescribed. * Once my health information has been disclosed, I understand that privacy laws may no longer protect the information. However, Titan agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law. I understand that certain parties, such as my pharmacy provider, may receive remuneration from Titan in connection with the activities described in this Authorization.

I authorize the use and/or disclosure of my health information for the following purposes: (1) for my enrollment, determination of my eligibility, and my treatment with Probuphine and participation in the Titan Access Program and for the administration of the program; (2) to help communicate with me, my health plan, my provider, or my pharmacy about my medical care and insurance status; (3) to verify my insurance information; (4) to provide education and ongoing support for my treatment as prescribed; (5) to refer me to alternative third-party patient programs; (6) to provide me with information about Titan products, health topics, and programs and ask for my opinions; (7) for business evaluation purposes; and (8) to comply with law. ~~This may include the occasional receipt and exchange of information with Titan for marketing purposes and I have the option to opt-out below~~. I understand and agree that Titan may contact me by mail, email, telephone, and/or text. Titan will generally leave voice messages with basic information. I authorize Titan to leave me voice messages with more detailed information about the reason for the call, which may contain more health information.

I understand that I may refuse to sign this Authorization and choose not to receive information or services from Titan. I understand that my treatment (including with a Titan product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. I may cancel or modify this Authorization at any time by writing to Titan at: Titan Access Program, PO Box 5038, Louisville, KY, 40255. Canceling this Authorization will end my consent after the date Titan receives my letter but will not affect information previously disclosed pursuant to this Authorization.

This Authorization shall be in effect for five (5) years from the date of my signature, unless a shorter period is required by law or it is canceled in writing. This Authorization is my copy to keep. I certify that all the information I provide to Titan is complete and accurate to the best of my knowledge.

*Any free product provided under the program cannot be submitted for reimbursement and shall be used as prescribed.