

PLEASE COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS

touchpointsSM Patient Enrollment Form

Vivitrol[®]
(naltrexone for extended-release injectable suspension)

Fax to: 877-329-8484

Reimbursement Hotline: 800-848-4876, select option #2

Prescribing Provider Information

Provider Name _____
FIRST LAST
Provider Tax ID # _____ Provider State License # _____
Provider Phone # _____ Fax # _____
Facility Name _____
Address _____
City _____ State _____ Zip Code _____
Staff Contact Name _____ Staff Contact Phone # _____
Staff Contact E-mail _____

Injection Provider Information

(Complete if referring to an Injection Provider/Facility other than your own)

Provider Name _____
FIRST LAST
Provider Tax ID # _____ Provider State License # _____
Provider Phone # _____ Fax # _____
Facility Name _____
Facility Address _____
City _____ State _____ Zip Code _____
Staff Contact Name _____ Staff Contact Phone # _____
Staff Contact E-mail _____

Will Your Office/Facility Be Injecting VIVITROL? (Check ONE)

- Yes, FREE first dose only Yes, ALL doses No, please locate an Injection Provider No, I will refer to the Injection Provider/Facility above

Preferred Specialty Pharmacy (if applicable) _____

Patient Information (MUST be completed for FREE first dose)

Name _____
FIRST LAST
Date of Birth _____ Gender Male Female
Address _____
City _____ State _____ Zip Code _____
Preferred Contact # _____
Secondary Contact # _____
E-mail _____

(Patient e-mail is REQUIRED for FREE 24/7 Recovery Support tools.)

Patient Diagnosis — Please Check ONE (MUST be completed for FREE first dose)

- Acute alcoholic intoxication in alcoholism unspecified drinking behavior (303.00)
 Acute alcoholic intoxication in alcoholism continuous drinking behavior (303.01)
 Other and unspecified alcohol dependence, unspecified (303.90)
 Other and unspecified alcohol dependence, continuous (303.91)
 Other and unspecified alcohol dependence, episodic (303.92)
 Other and unspecified alcohol dependence, in remission (303.93)
 Other Diagnosis, ICD-9 Code _____

Insurance Status (MUST be completed for FREE first dose)

- Insured Uninsured (Patient Assistance Program Requested; see next page)
 Patient paying out-of-pocket

Patient Insurance Information

(MUST be completed for FREE first dose)

Attach a copy of both sides of the patient's insurance card(s), or complete the insurance section below.

PRIMARY INSURANCE

Carrier Name _____ Carrier Phone # _____
Policyholder Name _____ Policy # _____
Policyholder Employer Name _____
Policy Group # _____ Relationship to Patient _____

SECONDARY INSURANCE

Carrier Name _____ Carrier Phone # _____
Policyholder Name _____ Policy # _____
Policyholder Employer Name _____
Policy Group # _____ Relationship to Patient _____

PHARMACY BENEFIT PLAN

Pharmacy Benefit Manager (PBM) Name _____
PBM Phone # _____
Policyholder Name _____ Policy # _____
Policyholder Employer Name _____
Policy Group # _____ Rx BIN # _____

Prescription Information (Not required for FREE first dose. However, is required for patient to receive ongoing monthly VIVITROL therapy.)

Patient Name _____ Date _____
FIRST LAST
VIVITROL 380 mg x 1 unit Inject 380 mg IM q4 weeks or q1 month Refill _____ times (Complete the number of refills to minimize interruption in monthly VIVITROL therapy for this patient.)
Provider State License # _____

Provider Attestation

Provider's Signature _____ Date of Signature _____

By signing above, I verify that the information provided in this Touchpoints enrollment form is complete and accurate to the best of my knowledge. I understand that Alkermes reserves the right at any time and for any reason, without notice, to modify this Touchpoints enrollment form or to modify or discontinue any services or assistance provided through Touchpoints. Finally, I authorize Alkermes, United BioSource Corporation, Chronic Disease Fund and DiseaseTrak™ as my designated agents and on behalf of my patient, to use and disclose my patient's health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through Touchpoints, to forward the above prescription, by fax or other mode of delivery, to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for patient assistance.



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Request for Product Sample

If provider is requesting a FREE first dose sample (Provider to complete):

To request a sample dose of VIVITROL, please complete (a) the Prescribing Provider Information section on page 1 of this form, (b) the Patient Information, Patient Diagnosis and Patient Insurance Information sections on page 1 of this form for purposes of enabling Touchpoints to perform insurance verification in the event you wish to continue your patient on VIVITROL, and (c) the remainder of the information requested below. **Your receipt of product sample is not in any way contingent upon completion of the Prescription Information section on page 1 of this form.**

The FREE first dose sample is only available for patients with COMMERCIAL INSURANCE who are new to VIVITROL therapy.

By signing below, I certify I am a licensed practitioner eligible to request, receive, prescribe and dispense this sample. If I am a Nurse Practitioner or Physician Assistant, I certify I am authorized and eligible, in the state in which I am now practicing, to request and receive this sample and I have my supervising Physician's approval to do so. I have requested this sample for the medical needs of my patients and I will not sell, resell, trade, barter, return for credit or seek third-party reimbursement for it.

VIVITROL 380 mg x 1 unit

Inject 380 mg IM q4 weeks or q1 month

Provider's Signature _____

Date of Signature _____

(PLEASE NOTE: THE PROVIDER WHO SIGNS MUST RECEIVE THE PRODUCT.)

Provider's Designation: MD DO NP PA

Alkermes reserves the right to rescind, revoke or amend this program.

Request for Co-pay Assistance

If patient is enrolling in the Alkermes Co-pay Assistance Program (Patient to complete):

AGREEMENTS AND CERTIFICATIONS

Certification and Acknowledgment: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand that I am free at any time to switch providers, practitioners or suppliers without affecting my continued eligibility for assistance. My application for assistance does not guarantee funding will be available. Any financial assistance for which I may be eligible will only be awarded after my enrollment documentation has been received and approved by Chronic Disease Fund. I understand that if I am awarded financial assistance that it will be provided on a 6-month basis. I must reapply each 6-month period, and the end of the 6-month period is my notice of cancellation. There is no guarantee that funding will be available in any subsequent period.

By signing below, I certify that no part of my prescription drug costs is paid for by Medicare, Medicaid, federal or state government funds, or by an insurer or other third-party payer in Massachusetts, and that my annual household income is less than \$125,000.

Signature of Patient or Patient's Representative _____

Date of Signature _____

(Form MUST be completed before signing)

PATIENTS WHO ARE ELIGIBLE MAY RECEIVE UP TO \$100 A MONTH IN CO-PAY ASSISTANCE FOR 6 MONTHS.

FREE Recovery Support Tools

By signing the authorization on page 3, patients will automatically be enrolled in Touchpoints Recovery Support, a FREE comprehensive program designed to help the patient keep track of their recovery progress.

The Touchpoints Recovery Support Program is a voluntary adherence and persistency program to support patients' ongoing commitment to recovery and to complement provider efforts.

Patient Authorization for Use/Disclosure of Health Information

By signing below, I **authorize** my prescribing physician, the healthcare provider designated to administer VIVITROL to me ("Administering HCP"), one or more network specialty pharmacies,* Cardinal SPS, United BioSource Corporation, Alliance, Group DCA, Chronic Disease Fund, DiseaseTrak[™] and Alkermes to **use and disclose** to each other my medical or other information set forth on the first page of this form, including information about my treatment with VIVITROL (taken together, "Information") **for the specific purposes** of ordering, delivering and administering VIVITROL, obtaining payment from my Health Plan(s), conducting reimbursement verification, *providing drug product samples and providing me with educational and therapy support services by mail, e-mail and/or telephone as requested on page 2 of this enrollment, and determining if I qualify for free product through patient assistance, or referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the costs of VIVITROL. I understand that support services may include product information materials and treatment reminders that may be of interest to me.* I understand that the parties to which I have authorized disclosure in this authorization may not be subject to applicable federal and state privacy laws and that my Information could be subject to redisclosure. If my prescribing physician or Administering HCP is providing me treatment at a federally assisted program under 42 CFR Part 2, my Information may not be used or further disclosed other than as provided in this authorization.

The patient or the patient's representative must read and check or initial the following statements:

- I understand that signing this authorization is voluntary and if I do not sign this authorization it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. I understand, however, *that if I do not sign this authorization, I will not be eligible to receive the educational and support services, co-pay assistance and other services described above.*
- I understand I have the right to receive a copy of this authorization after I sign.
- I understand that I may see a copy of the Protected Health Information described in this authorization if I request to do so.

If I applied to the Patient Assistance Program, I verify that my financial and other information provided in this enrollment is current, complete and accurate and understand that Alkermes may request documentation to verify financial or insurance information. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the patient assistance program. Alkermes reserves the right to make an independent determination of financial and medical need and, at any time and without notice, to modify or discontinue the patient assistance program with respect to any patient, or its entirety.

I may withdraw this authorization at any time by mailing or faxing a written request to Touchpoints Reimbursement Support; 4511 Singer Court; Suite 210; Chantilly, VA 20151 or by calling 1-800-VIVITROL. Withdrawal of this authorization will end further uses and disclosures of my Information by the parties identified in this authorization except to the extent those uses and disclosures have been made in reliance upon this authorization and as permitted by applicable law. This authorization expires five years from the date indicated below unless I withdraw it earlier.

Patient's Signature[†] _____ Date of Signature[†] _____

Parent/Guardian/Legal Representative's Signature[†] _____

Authority/Relationship to Patient _____

*Network Specialty Pharmacies include AccredoSM, Aetna Specialty Pharmacy[®], CVS/Caremark[®], CuraScript[®] and other specialty pharmacies providing similar services.

[†]If patient is a minor without capacity to act alone under state law, signature of patient and parent/guardian/legal representative is required.

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Aetna Specialty Pharmacy is a registered trademark of Aetna, Inc.

PrecisionRx Specialty Solutions is a pharmacy and department of NextRx, LLC.