

PLEASE COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS

touchpointsSM Patient Enrollment Form



Fax to: 877-329-8484

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

Prescriber Information

Prescriber Name _____
FIRST LAST

Prescriber Tax ID # _____ State License # _____

DEA # _____ Prescriber Phone # _____

Facility Name _____ Fax # _____

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 # _____ 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, ALL doses No, please locate an Injection Provider (see page 2 for details) No, I will refer to the Injection Provider/Facility above

Preferred Specialty Pharmacy (if applicable) _____

Special Shipping Instructions/Restrictions _____

Patient Information

Name _____
FIRST LAST

Date of Birth _____ Gender Male Female

Address _____

City _____ State _____ Zip Code _____

Preferred Contact # _____

Secondary Contact # _____

Alternate Contact Person if Patient Cannot Be Reached _____

Alternate Contact Person's Phone Number _____

Patient Diagnosis — Please Check All That Apply (See page 2 for Diagnosis Code Descriptions)

- | | |
|--------------------------------------|--|
| Alcohol Dependence | Opioid Dependence |
| <input type="checkbox"/> 303.00 | <input type="checkbox"/> 304.00 |
| <input type="checkbox"/> 303.01 | <input type="checkbox"/> 304.01 |
| <input type="checkbox"/> 303.90 | <input type="checkbox"/> 304.02 |
| <input type="checkbox"/> 303.91 | <input type="checkbox"/> 304.03 |
| <input type="checkbox"/> 303.92 | <input type="checkbox"/> 304.7___ (fifth digit required) |
| <input type="checkbox"/> 303.93 | |
| <input type="checkbox"/> Other _____ | |

Insurance Status

- Insured Uninsured Patient paying out-of-pocket

Patient Insurance Information

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 (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 # _____

Prescriber Attestation

Prescriber'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, and Opus Health as my designated agents 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 co-pay assistance.



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

Request for VIVITROL Value Program Co-Pay Assistance

\$0 CO-PAY UP TO \$500/MONTH FOR 13 MONTHS FOR ELIGIBLE PATIENTS*

The \$0 CO-PAY Program is only available for patients with **COMMERCIAL INSURANCE**.

Yes, I would like to participate in the \$0 CO-PAY Program. I certify that I meet the eligibility criteria below.

* Eligibility for Alkermes-sponsored co-pay assistance: Offer valid for prescriptions for alcohol dependence or for the prevention of relapse to opioid dependence, following opioid detoxification. Patients must be at least 18. Offer not valid for prescriptions purchased under Medicaid, Medicare, or any federal or state healthcare program, including any state medical or pharmaceutical assistance program. Offer not valid in Massachusetts. Offer not valid for cash pay patients. Void where prohibited by law, taxed or restricted. Alkermes, Inc. reserves the right to rescind, revoke or amend these offers without notice.

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.

Patient e-mail

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

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

Injection Provider Selection Information (as applicable)

If you have requested injection services for your patient, Touchpoints will provide a selection of several injectors based on geographic proximity to your patient's address listed on the enrollment form (from closest to farthest from such address).

These injection providers are listed in the VIVITROL Assisted Recovery Provider Locator* (posted on www.VIVITROL.com).

PLEASE NOTE: These options will normally be provided both in writing and via fax with a request for fast response so that coordination can be accomplished. If, after repeated attempts to contact you, we have not received a response, we will contact the geographically closest injection services provider to help coordinate injection services for your patient.

* Enrollment in the Locator is voluntary and free of charge and, along with the provider-specific information in the Provider Locator, is based on healthcare provider responses. Alkermes has not independently verified the qualifications of any healthcare provider included in the Locator. Alkermes disclaims all warranties, either express or implied, including but not limited to the implied warranties of merchantability and fitness for particular purpose. Alkermes shall in no event be liable to you or to anyone for any decision made or action taken by you in reliance on information.

Diagnosis Code Descriptions

Alcohol Dependence

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 drinking behavior (303.90)

Other and unspecified alcohol dependence continuous drinking behavior (303.91)

Other and unspecified alcohol dependence episodic drinking behavior (303.92)

Other and unspecified alcohol dependence in remission (303.93)

Opioid Dependence

Opioid type dependence unspecified use (304.00)

Opioid type dependence continuous use (304.01)

Opioid type dependence episodic use (304.02)

Opioid type dependence in remission (304.03)

Combination of opioid type drug with any other drug dependence (304.7__) (fifth digit required)

Alkermes

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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, Proherant, Group DCA, Opus Health, Nowspeed, Healthtalker, Evoke and Alkermes **to use and disclose** to each other and to my Designee(s), listed below, 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 me with educational and therapy support services by mail, e-mail and/or telephone and 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 re-disclosure. 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.

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 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 information described in this authorization if I request to do so.

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.

In addition, my Designee(s), listed below, is hereby authorized to receive administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding delivery of VIVITROL. Alkermes is not liable for any decision(s) made by the Designee(s) or actions taken in reliance on such Designee(s) decisions.

Designee Name _____ Relationship _____ Phone Number _____

Alternate Designee Name _____ Relationship _____ Phone Number _____

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

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

Authority/Relationship to Patient _____

*Network Specialty Pharmacies include Accredo[®], Aetna Specialty Pharmacy[®], CVS/Caremark[®], CuraScript[®], Walgreens Specialty Pharmacy[®] 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.

Accredo is a registered trademark of Accredo Health Group, Inc, a wholly owned subsidiary of Medco Health Solutions, Inc.

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

PLEASE SEE VIVITROL FULL PRESCRIBING INFORMATION INCLUDING BOXED WARNING AT www.vivitrol.com/pdf_docs/prescribing_info.pdf



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