Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Reset Form

zubsolv® sublingual tablets (buprenorphine and naloxone) C-III

ZUBSOLV Patient Assistance Program

ZUBSOLV Patient Assistance Program
50 Whittemore St., Gloucester, MA 01930
Phone: 888-236-4167 Fax: 888-246-6527

Applicant's Name: _____ Date of Birth: _____

Patient Instructions:

1. Complete all fields on page 1 and 2 of the application. Have your prescriber complete page 3 of the application. Incomplete applications will delay the processing of your application.
2. Sign and date the application.
3. Attach a copy of your valid driver's license or state photo ID.
4. Have your prescriber complete the third page of this application and write a prescription for ZUBSOLV.

YOUR INFORMATION

Name (first and last): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Daytime Phone: _____

Social Security # or Green Card # (if applicable): _____ Date of Birth: _____

Email: _____
By providing your email you are giving us permission to contact you in this way.

Fax: _____
By providing your fax you are giving us permission to contact you in this way.

Gender: (Check One) ☐ M ☐ F

Important:

1. **A person 18 years old or older must be present to sign for the medication.**
2. **We cannot ship the medicine to a P.O. Box**

Zubsolv Patient Assistance Program is a free program. We do not charge an application fee nor charge for the medication. You may apply to and contact the program directly without a third party paid advocate.

ELIGIBILITY INFORMATION

Residency Status: ☐ U.S. Citizen ☐ Legal Resident ☐ Work Visa (attach a copy your work visa)

My annual household income: _____

Required supporting documentation (select one):

- ☐ Applying before April 15 — copy of the first page of last year's federal tax return
- ☐ Applying after April 15 — copy of the first page of this year's federal tax return
- ☐ If on Social Security a copy of SSA 1099
- ☐ Copy of two most recent pay stubs for all employed household members
- ☐ Proof of all pensions, interest, alimony, child support and retirement payments for all household members
- ☐ If applicant has no income then a letter is required from applicant's healthcare provider, advocate or agency attesting to zero income or if you don't file taxes, submit the IRS response to Form 4506-T.

Number of family members in household including myself: _____

Check to confirm: ☐ I have no health insurance coverage (private or government) that pays for ZUBSOLV.

zubsolv® sublingual tablets (buprenorphine and naloxone) C-III

ZUBSOLV Patient Assistance Program

ZUBSOLV Patient Assistance Program
50 Whittemore St., Gloucester, MA 01930
Phone: 888-236-4167 Fax: 888-246-6527

Applicant's Name: _____ Date of Birth: _____

MEDICAL QUESTIONS

List all the medications you are currently taking, including over-the-counter medicines (those you can buy without a prescription), supplements, natural remedies, etc. If you are taking no medications, then check this box: ☐ NONE.

_____

_____

_____

List any allergies to medications you have. If you have no allergies, then check this box: ☐ NONE.

_____

_____

_____

List any medical conditions you have, including any relative to this application.
If you have no medical conditions, then check this box: ☐ NONE

_____

_____

_____

THE AGREEMENT

You must sign the form before we can process your application and deliver your medication. I attest that the information in this application is true, complete and accurate. This authorization or a copy shall be valid for 6 months from the date of signature. I understand that the ZUBSOLV Patient Assistance Program reserves the right to request additional income verification or other information from me and may refuse my application based on any misuse, abuse or illegal distribution of any products in this program. **I understand that the ZUBSOLV Patient Assistance Program does not charge a fee for participation in the program. If I have used a third party who charges a fee for help with my enrollment form or refills of my medicine, this money is not paid to ZUBSOLV Patient Assistance Program.**

Applicant's or Legal Guardian Signature: _____ Date: _____

If you would like to give permission to the ZUBSOLV Patient Assistance Program for other individuals (i.e. adult child, parent, friend) to conduct business on your behalf, please print their name(s) here. Please note: These individuals are in addition to a legal guardian or registered advocate who may already be included on this application.

Name: _____ Name: _____

SUBMITTING THE COMPLETED APPLICATION

Mailing Instructions:

1. Make sure all the questions are answered, the applicant and prescriber have signed the application, you attached a copy of your valid driver's license or state photo ID, and the prescriber has written a prescription.
2. The prescriber may fax the application from the office fax to: 888-246-6527
3. Either you or the prescriber can mail the application to:

   ZUBSOLV Patient Assistance Program
   50 Whittemore St.
   Gloucester, MA 01930

zubsolv® sublingual tablets (buprenorphine and naloxone) C-III

ZUBSOLV Patient Assistance Program

ZUBSOLV Patient Assistance Program
50 Whittemore St., Gloucester, MA 01930
Phone: 888-236-4167 Fax: 888-246-6527

Applicant's Name: _____ Date of Birth: _____

PRESCRIBER INSTRUCTION

1. Complete all fields on the application.
2. Sign the application.
3. Include prescription copy for ZUBSOLV - See prescribing details below.
4. Mail the application to: ZUBSOLV Patient Assistance Program, 50 Whittemore St., Gloucester, MA 01930. Original prescription must be mailed, escribed or called in to:
   GoGoMeds, 525 Alexandria Pike, Ste. 100, Southgate, KY 41071. Phone: 888-795-5826. NCPDP #1834793.

Incomplete applications or missing information will delay the processing of the application.

PHYSICIAN INFORMATION

Prescriber's Name: _____ Facility/Practice: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

XDEA Number: _____ NPI Number: _____

State License Number: _____ Expiration Date: _____

Email: _____ Fax: _____

By providing your email you are giving us permission to contact you in this way.

By providing your fax you are giving us permission to contact you in this way.

☐ Check box to have prescription sent to the physician's address listed above. Otherwise, the prescription will be sent to the patient's home address.

PRESCRIPTION REQUIREMENTS

You must follow these instruction or your prescription may be rejected:

1. The prescription must be written on a blank with your name, address, and phone number preprinted.
2. The prescription must include the ICD-10 code (F11.20 or F11.21)
3. The prescription must include your XDEA number and state license number. Prescriptions must be written by a physician and cannot be written by a physician assistant (PA).
4. Specify "ZUBSOLV 5.7mg/1.4mg buprenorphine/naloxone" and/or "1.4mg/0.36mg with maximum daily dose of 17.1mg buprenorphine/naloxone per day" with the number of tablets taken per month (30, 60 or 90).
5. Specify up to 5 refills.
6. Specify the patient instructions.
7. Mail, escribe, or call in the prescription to GoGoMeds. Phone: 888-795-5826.

You can only have one patient on this program at any one time.

PATIENT INFORMATION

Please indicate the diagnosis that justifies the need for this medication: _____

ICD-10 Code: ☐ F11.20 ☐ F11.21 ☐ Other_____

PRESCRIBER ATTESTATION

You must sign the form before we can process your patient's application and send the medication.

I attest that the information in this application is true, complete and accurate. This authorization or a copy shall be valid for 6 months from the date of signature. I understand that ZUBSOLV Patient Assistance Program reserves the right to request additional information from me and may refuse my application based on any misuse, abuse or illegal distribution of any products in this program.

To the best of my knowledge, this patient is financially needy, has no insurance coverage for the ZUBSOLV and has a medical need for this medication.

Prescriber's Signature: _____ Date: _____