Reset Form

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

ZUBSOLV Patient Assistance Program

ZUBSOLV Patient Assistance Program
23290 Schoenherr Rd, Warren, MI 48089
Phone: 888-772-3811 Fax: 586-772-6873

Applicant Name: _____ Date of Birth: _____

Patient Instructions:

1. Complete all fields on pages 1 and 2 of the application. Sign and date the application as instructed on page 2.
2. Attach a copy of your valid driver's license or state photo ID.
3. Have your prescriber complete pages 3 and 4 of the application and submit the fully completed application as directed with a valid 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.

Sex: (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.**
3. **You will need a new prescription for ZUBSOLV after 6 months from the original prescription date or when no refills remain, whichever comes first.**
4. **Program participation valid for 12 months. Participation beyond 12 months must be approved on a case-by-case basis.**

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 of 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.

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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 all 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 up to 12 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. I agree to the Consent for Use and Disclosure of Substance Use Disorder Treatment Information as presented on page 5 of this form.**

Applicant or Legal Guardian Signature: _____ Date: _____

If you would like to give permission to the ZUBSOLV Patient Assistance Program for other individuals (e.g., 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

Submission Instructions:

1. Make sure all the questions are answered, the applicant and prescriber have signed the application, the applicant has provided a copy of a 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: 586-772-6873 or mail to:

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PRESCRIBER INSTRUCTIONS

1. Complete all fields on the application.
2. Sign the application.
3. Include a copy of the prescription for ZUBSOLV - See prescribing details below.
4. Fax the completed application from the office fax to: 586-772-6873
   or mail to: ZUBSOLV Patient Assistance Program, 23290 Schoenherr Rd, Warren, MI 48089.
   Original prescription must be e-scribed or sent to:
   American Mail Order Pharmacy. Phone: 586-772-6872. NCPDP: 2370269.

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

PRESCRIBER INFORMATION

Prescriber's Name: _____ Facility/Practice: _____

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

Telephone: _____ Fax: _____

DEA 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 the medication sent to the prescriber's address listed above. Otherwise, the medication will be sent to the patient's home address.

PRESCRIPTION REQUIREMENTS

You must follow these instructions or the prescription may be rejected:

1. The prescription must be submitted electronically. Exceptions may be made on a case-by-case basis according to state law. Please contact the pharmacy for further information.
2. The prescription must include the ICD-10 code (F11.20 or F11.21)
3. The prescription must include the prescriber's DEA number and state license number. Prescriptions must be written in accordance with applicable state and federal regulations.
4. Specify the strength of both active ingredients and either "ZUBSOLV" or "buprenorphine/naloxone" with the number of tablets taken per month (30, 60, or 90).
5. Specify number of refills (max of 5 refills within a 6-month period). A new prescription is required every 6 months or once all authorized refills have been used, whichever occurs first.
6. Specify the patient instructions.
7. E-scribe the prescription to American Mail Order Pharmacy. NCPDP: 2370269.

PATIENT INFORMATION

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

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

Please indicate if this is a new patient application or request for a program extension for an existing patient:

☐ New patient application ☐ Application for program extension*

* After the patient completes 12 months on the program, if they still require assistance, they may apply for an extension up to the end of the calendar year in which the 12-month duration expires. Patient will need to complete the application with extension request details indicated by prescriber and provide updated proof of household income. An appeal letter will need to be provided by the prescriber requesting the extension.

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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 up to 12 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.

I attest that I have diagnosed this patient with Opioid Use Disorder and that I am prescribing this medication only for the treatment of Opioid Use Disorder.

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

Print Name of Prescriber: _____

Prescriber Signature: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF SUBSTANCE USE DISORDER TREATMENT INFORMATION

I understand that records relating to my diagnosis, treatment, or referral for treatment for a substance use disorder may be protected by federal law, including 42 U.S.C. § 290dd-2 and 42 CFR Part 2 ("Part 2 Records").

I authorize any healthcare provider, treatment program, physician, pharmacy, health plan, pharmacy benefit manager, hospital, clinic, or other lawful holder of my Part 2 Records to disclose such records to Dexcel Pharma USA, its affiliates, contractors, service providers, specialty pharmacies, and other parties acting on its behalf (collectively, "Dexcel"), to the extent necessary to administer the Zubsolv® Patient Assistance Program ("Program").

The information that may be disclosed includes information relating to my substance use disorder diagnosis, treatment, medications, prescriptions, healthcare providers, insurance coverage, benefits, and other information reasonably necessary to determine eligibility for, enroll me in, and administer the Program, including medication access, reimbursement support, and related patient support services.

My records may be used and disclosed by Dexcel as permitted by applicable federal and state law. Information disclosed pursuant to this content may be subject to redisclosure only as permitted by law.

The purpose of this disclosure is to determine my eligibility for the Program, facilitate enrollment and continued participation in the Program, coordinate access to medication and related support services, verify insurance coverage, obtain reimbursement support, and administer Program operations.

I understand that I may revoke this consent at any time by providing written notice to Dexcel at pap@dexcelpharmausa.com, except to the extent that action has already been taken in reliance on this consent. I understand that revoking this consent will terminate my participation in the Program if the Program cannot be administered without access to the information covered by this consent.

Unless revoked earlier, this consent will remain in effect for the duration of my participation in the Program and for one (1) year thereafter, or until the occurrence of the following event: the conclusion of all Program-related activities concerning my application and participation in the Program.

I understand that federal law permits the recipient of my Part 2 Records to use and disclose such information only as permitted by applicable law, including 42 CFR Part 2. I understand that my substance use disorder treatment information may be protected by additional confidentiality requirements and that unauthorized use or disclosure may be prohibited by law.

I have read and understand this Consent for Use and Disclosure of Substance Use Disorder Treatment Information and voluntarily consent to the disclosure of my Part 2 Records as described above.

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