SUBSYS®
(fentanyl sublingual spray)
100,200,400,600,800,1200,1600 mcg

INSYS Ancillary Services
Patient and Healthcare Provider Consent Form

Fax form to: (844) 793-4412

PLEASE NOTE: These programs are only provided for patients with the indication below.

INSYS PRESCRIBER CONSENT (please read carefully):

(i) My patient has provided all required written authorization(s) as required by HIPAA 164.508 and other federal or state laws to release to INSYS all Personal information needed for this application, including without limitation, financial and personally identifiable information for the purposes of assessing patient's eligibility for participation in the Patient Assistance Program ("Program"), including verifying my patient's insurance coverage, facilitating prior authorization or denials if needed, or referring patient to other programs or alternate sources of funding or coverage. I also attest that all the information provided in this application is complete and accurate. If I become aware of any errors in the information provided, I will promptly notify INSYS of those errors. I understand and have explained to my patient that INSYS may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any part of the Program. INSYS agrees to safeguard any Personal information it obtains through this application and will use and disclose this Personal information only as permitted herein or as required by law.

I attest that this patient has the following (must be checked without edits):

☐ **Breakthrough Cancer Pain, is age 18 or older and is opioid tolerant**

☐ **Enroll my Patient for Consideration for Compassionate Patient Assistance Program (CPAP) [process on reverse side]**

Enter dispensing INSYS Network Specialty Pharmacy for CPAP (Required): _____

☐ **Please send a Patient Starter Kit to my patient at their address below**

To ensure outreach by the Patient Support Services Program, your patient must complete the "Patient Information" section below.

Prescriber Name (please print) _____Prescriber NPI _____

Prescriber Signature _____Date _____

Contact Name at HCP Office _____ Phone _____ Fax_____

- Signatory is registered with the TIRF REMS Access Program and understands the intended use of SUBSYS® and all associated contraindications.
- Prescriber has reviewed the Product Information and the patient record and attests that there are no contraindications and the prescription conforms to the requirements of the Product Information, REMS requirements and applicable law.

INSYS PATIENT AUTHORIZATION AND CONSENT TERMS (please read carefully):

I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal information") to INSYS Therapeutics Inc. (including sales personnel, Business Relations Managers, patient support staff and nurses), its affiliates, business partners, and agents (together, "INSYS") so that INSYS can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with INSYS product(s), (ii) coordinate my receipt of, and payment for INSYS product(s), (iii) facilitate my access to INSYS product(s), (iv) provide me with information about the appropriate use of INSYS product(s), disease awareness and clinical care management programs and educational materials (together, the "Support Program"), and (v) conduct market research, data analytics, quality assurance, resource allocation, and other internal business activities. I understand that an independent third-party source will be used to verify my income if considered for the CPAP program. I understand and agree that third-party verification will be used solely to verify income and my credit report will be viewed. This does not affect my credit report. I authorize INSYS to disclose my Personal information to any pharmacies, my insurance insurer(s), healthcare providers (including my doctor(s) and their staff) and other third parties for the purposes described above. I authorize INSYS to contact me directly for the purposes described above. I understand that I may choose the dispensing pharmacy in accordance with my insurance and/or prescriber recommendation. I agree to receive telephone calls, emails, and mailing materials from INSYS at the telephone number(s) and address(es) provided on this Authorization Form. I understand that my cell phone carrier's standard rates may apply for calls to my cell phone. I understand and agree that Personal information transmitted by email and cell phone cannot be secured against unauthorized access. I understand and agree that my pharmacy, health insurance company and healthcare providers may receive remuneration from INSYS Therapeutics Inc. in exchange for disclosing my Personal information to INSYS Therapeutics Inc. and/or for providing me with therapy support services subsidized by INSYS Therapeutics Inc. I understand that once my Personal information is disclosed it may no longer be protected by federal or state law regarding patient privacy. INSYS will take commercially reasonable steps to ensure the security and privacy of my Personal information. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my doctor(s); however, if I do not sign or revoke this authorization, I may no longer be eligible to participate in any support program(s) offered by INSYS. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that any support program(s) offered by INSYS may be changed or ended at any time without prior notification. I understand that I may receive a copy of this authorization. Withdrawal of this authorization will end further uses and disclosures of my Personal information by INSYS, except to the extent those uses or disclosures have been made in reliance upon this authorization. I may send my request to revoke this authorization at any time, except to the extent action may have already been taken based on this, to 1333 S Spectrum Blvd #100, Chandler 85286.

----------Patient Information----------

Name (Please Print): _____ Signature: _____ Date: _____

DOB: _____ Gender: _____ Phone Number (Required): _____

Street Address (Please Print): _____ City: _____ State: _____ Zip: _____

If Patient Wishes to Delegate

I, (Patient Name) _____, designate _____ (Guardian, Caregiver or Family Member) to act on my behalf for all matters relating to my INSYS Therapeutics treatments.

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Fax this form to: (844) 793-4412
Questions? Call: (844) 309-3835

INSYS Network Specialty Pharmacies - Servicing patients in all 50 states:

• Avella Deer Valley (Main Location):	23620 N. 20th Drive - Suite 12 Phoenix, AZ 85085	P: (877) 546-5779 F: (888) 901-3609
• Dunn Meadow:	1555 Center Ave - 1st Floor Fort Lee, NJ 07024	P: (201) 949-3411 F: (201) 949-3455
• ReCept RX:	4011 Crescent Park Drive Riverview, FL 33578	P: (844) 378-7784 F: (844) 378-7785

INSYS Network Specialty Pharmacies utilize e-prescribing, fax and mail for prescription filling.

Bridge Voucher Process

Step 1: HCP faxes this completed form to the PSC and submits weekly Rx to INSYS Network Specialty Pharmacy

Step 2: INSYS Network Specialty Pharmacy requests Bridge Voucher after initiating the case with the PBM

Step 3: Voucher is issued to Specialty Pharmacy if eligibility requirements are met
- Up to eight weeks of support while the Specialty Pharmacy actively works the case with the PBM

Step 4: Specialty Pharmacy will contact patient to set up delivery

Compassionate Patient Assistance Program (CPAP)

Step 1: Submit all documentation via fax to (844) 793-4412
1) This form with chosen INSYS Network Specialty Pharmacy, and HCP & patient signatures
2) Appeal Denial Letter from payor
3) Letter of Medical Necessity

Step 2: INSYS Network Specialty Pharmacy contacts HCP to conduct clinical review

Step 3: Third party vendor contacts patient for income verification

Patient Support Services Program (PSSP)

PSSP is available to indicated patients with a signature on file. Please fax the reverse side of this form to (844) 793-4412 for the PSSP to call your patient. For questions on the program, please call (844) 309-3834.

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