zubsolv® sublingual tablets (buprenorphine and naloxone) CIII

ZUBSOLV Patient Assistance Program

ZUBSOLV Patient Assistance Program
PO Box 219, Gloucester, MA 01931
Phone: 888-236-4167 Fax: 888-246-6527

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 the application.
3. Make 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**

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 other person or agency attesting to zero income

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 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.

Applicant's Signature: ____________________________ Date:________________

SUBMITTING THE COMPLETED APPLICATION

Mailing Instructions:

1. Make sure all the questions are answered, the applicant and prescriber have signed the application, you made 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 and prescription from the office fax to: 888-246-6527
3. Either you or the prescriber can mail the application and prescription to:

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   PO Box 219
   Gloucester, MA 01931

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PRESCRIBER INSTRUCTION

1. Complete all fields on the application.
2. Sign the application.
3. Attach a prescription for ZUBSOLV - See prescribing details below
4. Mail the application to: ZUBSOLV Patient Assistance Program, PO Box 219, Gloucester, MA 01931 or fax from your office fax to: 888-246-6527

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: ______________________
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.

☐ 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

Your 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 your XDEA number and state license number.
3. 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).
4. Specify up to 5 refills.
5. Specify the patient instructions.
6. **You can only have one patient on this program at any one time.**

PATIENT INFORMATION

Please select the diagnosis that justifies the need for this medication:

☐ Treatment of opioid dependence

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: ______________