BRAEBURN ByYourSide

Enrollment Form

If preferred, you may enroll a patient online using the Braeburn ByYourSide Portal at braeburnbyyourside.caremetx.com/login

INSTRUCTIONS: To enroll a patient in the Braeburn ByYourSide (BBYS) program for BRIXADI® (buprenorphine) extended-release injection for subcutaneous use (CIII), **complete and fax both pages of this form to 877-335-2294.** Complete all required fields and ensure both the prescriber and patient have signed. For general information, call BBYS at 877-279-7367 (8 am-8 pm EST M-F).

*Required fields.

***Select program options (choose all that apply):**

☐ **Specialty pharmacy identification** ☐ **Prior authorization support** ☐ **Other support** _____
☐ **Benefit investigation** ☐ **Appeals support**

***Acquisition path (required):**

☐ **Specialty pharmacy** **Prescriber's preferred SP** _____
☐ **Buy and bill**

1 Patient Information

*First Name:	*Last Name:		*DOB: MM / DD / YYYY
*Address:	*City:	*State:	*ZIP Code:
Preferred Language (English, Spanish, other):	*Gender: ☐ Male ☐ Female ☐ Undisclosed		Email:
*Preferred Phone Number:	☐ Home ☐ Cell	Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening	
Authorized Alternate Contact/Care Partner:		Relationship to Patient:	
Alternate Contact/Care Partner Phone:		☐ OK to leave a message with the alternate contact/care partner	
Is your patient receiving medication for OUD? ☐ Yes ☐ No Date of Last Injection (if applicable): MM / DD / YYYY		☐ *OK to leave a message with the patient	

2 Patient Insurance Information

Please fax a copy of both sides of the patient's insurance card(s).

***Primary Medical Insurance:**	*Plan Name:	*Insurance Phone:	
*Policy ID #:	*Group #:	Medicare Beneficiary ID #:	
*Policyholder Name (First, Last):	*Policyholder DOB: MM / DD / YYYY	Relationship to Patient:	
Prescription Drug Plan:	Prescription Drug Plan Phone:		
Policy ID #:	Group #:	Rx BIN #:	Rx PCN #:
Secondary Medical Insurance:	*Plan Name:	Insurance Phone:	
Policy ID #:	Group #:	Medicare Beneficiary ID #:	
Policyholder Name (First, Last):	Policyholder DOB: MM / DD / YYYY	Relationship to Patient:	

3 BRIXADI Copay Savings Program (Optional: for commercially insured, eligible patients only)

☐ Patient is enrolled in the BRIXADI Copay Savings Program	Copay ID#:

4 Patient Authorization for Use and Disclosure of Protected Health Information

I hereby authorize 1. my doctor(s), **2.** their staff, **3.** my health insurer(s), and **4.** specialty pharmacy or distributor that will supply BRIXADI and/or fill my prescription to disclose my personal information, including but not limited to **a.** information about my medical condition and treatment (including prescriptions), **b.** health insurance, and **c.** related identifying information ("Personal Information") to Braeburn Inc., its business partners, agents, and contractors (collectively "Braeburn") to enroll me in the Braeburn ByYourSide Program and/or programs or services selected above. I authorize the Braeburn ByYourSide Program Support Team to contact me by phone or other electronic means at the telephone number(s) listed on this form. I understand that my Personal Information will be used and disclosed by and among Braeburn, its business partners, agents, and contractors, my doctor(s) and their staff, my health insurer(s), and specialty pharmacies or distributors to **1.** help verify reimbursement and investigate or coordinate insurance coverage, **2.** coordinate my receipt of and payment for BRIXADI, **3.** enroll me in and contact me about the Program, **4.** provide education, information, products, programs, and reimbursement support services related to my treatment with BRIXADI, **5.** permit Braeburn to manage the Program and conduct market analyses or other commercial activity, including aggregating my Personal Information with other data, and **6.** assist with analysis related to quality, efficacy, and safety for BRIXADI. Braeburn agrees to use and disclose my Personal Information only for the purposes described in this Authorization or as required by law. **Information May Be Further Disclosed:** I understand that Information disclosed pursuant to this authorization could be re-disclosed by a Recipient and may no longer be protected by federal privacy law (HIPAA). I understand that my pharmacy, health insurers, and third-party vendors may receive payment from Braeburn, Inc. in exchange for disclosing my Personal Information. I also understand that the Braeburn ByYourSide Program may be changed or ended at any time without my prior consent. I understand that this authorization expires ten years from the date signed above unless a shorter period is required by state law. I understand that I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy of this Authorization, and that I can cancel this Authorization at any time by calling 1-833-274-9234 or writing to Braeburn Inc., Attn: Braeburn ByYourSide Support: 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746.

SIGN *Patient Signature Required

Date: MM / DD / YYYY

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*Patient Name: _____ *DOB: MM / DD / YYYY *Healthcare Provider Name: _____

5 Clinical Information (Ensure ICD-10 diagnosis code is provided)

Scheduled Injection Date: MM / DD / YYYY (if known)

*Check Off Prescribed Dose: BRIXADI **Weekly** ☐ 8 mg ☐ 16 mg ☐ 24 mg ☐ 32 mg BRIXADI **Monthly** ☐ 64 mg ☐ 96 mg ☐ 128 mg

***Primary Diagnosis (ICD-10 Code):**

6 Prescriber Information

*Prescriber Name:		*Prescriber NPI #:	
State License #:		License State:	License Expiration Date: MM / DD / YYYY
Supervising Physician Name (if appropriate):		Supervising Physician DEA #:	
*Office Address:		*City:	
*State:	*ZIP Code:	*Phone:	*Fax:
*Office Contact Name:	*Contact Email Address:	*Office Contact Phone:	
*Facility Name:	Practice NPI #:	Facility Type: ☐ Provider Office ☐ Outpatient Treatment Facility ☐ Other	
Medicaid Provider #:		Prescriber DEA #:	
DEA Shipping Address of Prescriber (if different from above):			
Shipping Location DEA # (if different from above):			
*Provider Tax ID:	*Facility Tax ID:	*Medicare PTAN (if applicable):	

BRIXADI orders cannot be fulfilled unless the shipping address matches the registered address on file with the DEA for the administering practitioner.

7 Prescriber Certification

I certify that the information provided in this BBYS Enrollment Form is complete and accurate to the best of my knowledge. I have prescribed BRIXADI based on my independent medical judgment that BRIXADI is medically necessary, and I will supervise the patient's medical treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to provide the individually identifiable health information on this form to agents and service providers of Braeburn Inc. for use, including, but not limited to, benefits eligibility, coverage authorization, and the coordination and dispensing of BRIXADI.

SIGN *Prescriber Signature Required Date: MM / DD / YYYY

Signature stamps not acceptable.