Provider Locator Agreement

touchpoints℠ Support Services
Connecting people with care in recovery

Terms of Participation

Your name, address and other information that you provide to us will be used by Alkermes, Inc. and entities with which Alkermes has a relationship, pursuant to which your information may be made available to other healthcare providers, patients and consumers who wish to access your services. We may contact you by e-mail, postal mail or telephone to verify and update your profile, make you aware of new website functions or capabilities on the Provider Locator Tool, notify you as to any changes in eligibility criteria related to the Provider Locator, and to provide information on treatment options and other programs that may interest you. Alkermes, Inc. will not share your information with anyone else except as described above or as required by law. If you want to stop receiving this information, you may ask us to remove you from our contact list by calling Touchpoints Support Services at 1-800-VIVITROL (1-800-848-4876). Inclusion of your name and organizational information as part of our Touchpoints Support Services does not represent, and will not necessarily result in, any endorsement, referral or recommendation by Alkermes, Inc. or Touchpoints Support Services and your agreement to be listed in the Provider Locator shall not be construed as an inducement or encouragement for the referral of patients or use of particular products. The Physician Locator lists three types of Healthcare Providers: Medical Management Providers, VIVITROL Injection Providers, and Psychosocial Counseling Providers. In some instances, a Healthcare Provider may be able to provide more than one of these services. In order to be included within the VIVITROL Physician Locator as one or more of these types of Healthcare Providers, you must be validly licensed (as required by state or federal law) and meet all of the criteria outlined in the respective Healthcare Provider type listed below. In order to be included in the Touchpoints Support Services, you must meet the specific requirements for the appropriate provider type below, as well as validly licensed, if and as required by state law: Medical Management Provider (i.e., physicians, nurse practitioners, physician assistants): (A) Able to write prescriptions for pharmaceutical products (B) Experienced in prescribing VIVITROL for the treatment of alcohol and/or opioid dependence (C) Willing to accept new patients, provided they meet the requirements of the Healthcare Provider's practice (i.e., accepted insurance types, etc.) (D) If and as necessary, willing and able to refer patients to other Healthcare Providers for injection of VIVITROL and the provision of psychosocial services. VIVITROL Injection Provider (i.e., physicians, licensed nurses, physician assistants): (A) Able to reconstitute and inject VIVITROL in accordance with the FDA-approved product labeling (B) Willing to receive patient referrals for injection of VIVITROL, provided they meet the requirements of the Healthcare Provider's practice (i.e., accepted insurance types, etc.) (C) If and as necessary, willing and able to refer patients to other Healthcare Providers for the provision of psychosocial services. Psychosocial Counseling Provider (i.e., counselors): (A) Able and willing to provide psychosocial support to patients treated with VIVITROL (B) Willing to accept patient referrals for the provision of psychosocial support to patients treated with VIVITROL, provided they meet the requirements of the Healthcare Provider's practice (i.e., accepted insurance types, etc.) (C) If and as necessary, willing and able to refer patients to other Healthcare Providers for medical management with VIVITROL and the injection of VIVITROL. You acknowledge that you have received, read and understood the full Prescribing Information for VIVITROL (naltrexone for extended-release injectable suspension), including the directions for administration and use of the product. You are fully and solely responsible for the quality of care to be provided at your site of care.

PRIMARY FACILITY:

INPATIENT

☐ Treatment Center ☐ Inpatient Hospital ☐ Detox Facility ☐ Psychiatric Hospital ☐ Other (specify): _____

OUTPATIENT

☐ Private Practice ☐ Group Practice ☐ Hospital Outpatient Department ☐ Intensive Outpatient Program (IOP) ☐ Injection Clinic ☐ Clinic
☐ Community Mental Health Center (CMHC) ☐ Partial Hospitalization Program (PHP) ☐ Federally Qualified Healthcare Center (FQHC)
☐ Other (specify): _____

Name of Primary Practice/Facility _____
Phone_____ Fax _____
Address_____ City _____ State_____ Zip _____
Facility Website_____ DEA #_____ NPI #_____ ME #_____
Email _____ Best Time to Call _____

VIVITROL-Related list of Services Offered (check all that apply)
☐ Counseling ☐ Medical Management ☐ VIVITROL Injection for Your Patients ☐ VIVITROL Injection for Other Practices

Hours That Site is Available for Providing Injections: M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun_____

Do you have experience injecting VIVITROL? ☐Yes ☐No Will You Accept Buy and Bill? ☐Yes ☐No

Does this facility treat: ☐ Alcohol Dependence ☐ Opioid Dependence ☐ Both

PRIMARY PROVIDER:

Name of primary provider at the above facility _____

Does the primary provider at this facility also have a secondary facility? ☐Yes ☐No (If yes, please complete side 2 of this form.)

Are there secondary providers at the above facility? ☐Yes ☐No (If yes, please complete side 2 of this form.)

By signing the below, I hereby certify that I have read, understood and agree to comply with the terms of participation set forth above. The undersigned is the above-named provider, or if I am signing on behalf of a facility, I certify that I am authorized to do so.

Name/Title (please print) _____
Signature _____Date of Signature_____
Alkermes reserves the right to alter or discontinue this program at our discretion.

Please return this form via mail or fax to:
ATTN: Touchpoints Support Services, United BioSource Corporation
1670 Century Center Parkway
Memphis, TN 38134
Fax: 1-877-329-8484

Please see Prescribing Information and Medication Guide or visit VIVITROL.com

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SECONDARY FACILITY FOR PRIMARY PROVIDER LISTED ON PAGE 1:

INPATIENT
☐ Treatment Center ☐ Inpatient Hospital ☐ Detox Facility ☐ Psychiatric Hospital ☐ Other (specify): _____

OUTPATIENT
☐ Private Practice ☐ Group Practice ☐ Hospital Outpatient Department ☐ Intensive Outpatient Program (IOP) ☐ Injection Clinic ☐ Clinic
☐ Community Mental Health Center (CMHC) ☐ Partial Hospitalization Program (PHP) ☐ Federally Qualified Healthcare Center (FQHC)
☐ Other (specify): _____

Name of Secondary Practice/Facility _____
Phone_____ Fax _____
Address_____ City _____ State_____ Zip _____
Facility Website_____ DEA #_____ NPI #_____ ME #_____
Email _____ Best Time to Call _____

VIVITROL-Related list of Services Offered (check all that apply)
☐ Counseling ☐ Medical Management ☐ VIVITROL Injection for Your Patients ☐ VIVITROL Injection for Other Practices

Hours That Site is Available for Providing Injections: M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun_____

Do you have experience injecting VIVITROL? ☐Yes ☐No Will You Accept Buy and Bill? ☐Yes ☐No

Does this facility treat: ☐ Alcohol Dependence ☐ Opioid Dependence ☐ Both

SECONDARY PROVIDER AT PRIMARY FACILITY ON PAGE 1:

Name of secondary provider _____
Facility name of secondary provider _____

By signing the below, I hereby certify that I have read, understood and agree to comply with the terms of participation set forth above. The undersigned is the above-named provider, or if I am signing on behalf of a facility, I certify that I am authorized to do so.

Name/Title (please print) _____
Signature _____Date of Signature_____

SECONDARY PROVIDER 2:

Name of secondary provider _____
Facility name of secondary provider _____

By signing the below, I hereby certify that I have read, understood and agree to comply with the terms of participation set forth above. The undersigned is the above-named provider, or if I am signing on behalf of a facility, I certify that I am authorized to do so.

Name/Title (please print) _____
Signature _____Date of Signature_____

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touchpoints℠ Support Services
M-F, 9:00 AM to 7:00 PM ET
Phone: 1-800-848-4876
Fax: 1-877-FAX-VIVI (1-877-329-8484)