PATIENT ENROLLMENT FORM

reSET® reSET-O®

Phone: 1-833-MY-RESET • **Fax:** 1-877-256-1320
Email: PearConnect@PearTherapeutics.com
Hours of Operation: Monday through Friday, 8AM - 8PM ET

Please complete all fields indicated to prevent any delays in filling the prescription.

* Indicates a required field.

PATIENT

*Name: (First, Middle Initial, Last) _____

Sex: ☐ M ☐ F *DOB: ___/___/___ *Address: _____ Apt/Suite: _____

*City: _____ *State: _____ *ZIP: _____ *Email: _____

*Cell Phone: _____ Alt Phone: _____

☐ Okay to leave a reSET Connect™ voicemail†

† I authorize reSET Connect to leave a detailed voicemail message for me at the numbers provided above. I understand that the message may include any information, including my personal information and information about my use of reSET Connect. I also understand that, if others have access to my voicemail, there is a possibility that they may hear a message left by reSET Connect

CANNOT PROCESS FORM WITHOUT THIS COMPLETED

☐ I have read and agree to the Telephone Consumer Protection Act (TCPA) consent on page 3 (optional).

X _____ _____/_____/_____

Patient/Legal Guardian Signature **Date of Signature (MM/DD/YYYY)**

I have read and agree to the attached Patient Authorization (page 3).

INSURANCE

Complete this section OR provide a copy of patient's insurance and pharmacy benefit cards. Include both front AND back of cards.

***Medical** Plan Name: _____

Phone: _____

*Member ID: _____

Group #: _____

Cardholder Name: _____

Relationship to Cardholder:

☐ Self ☐ Spouse ☐ Child ☐ Other

Pharmacy Benefit Plan Name: _____

Rx Helpdesk: _____

Rx Member ID: _____

Rx Group #: _____

Rx Bin #: _____

Rx PCN #: _____

Cardholder Name: _____

PEAR THERAPEUTICS | SANDOZ A Novartis Division

PHYSICIAN

LICENSED CLINICIAN

* Indicates a required field.

*Name: _____

*Clinic/Practice: _____

NPI #: _____

Contact Person: _____

Office Phone: _____

Fax: _____

*Email: _____

Cell Phone: _____

*Address: _____

Apt/Suite: _____ *City _____

*State: _____ *ZIP: _____

ADDITIONAL CLINICIAN OR THERAPIST (OPTIONAL)

☐ N/A

*Name: _____

*Clinic/Practice: _____

NPI #: _____

Contact Person: _____

Office Phone: _____

Fax: _____

*Email: _____

Cell Phone: _____

*Address: _____

Apt/Suite: _____ *City _____

*State: _____ *ZIP: _____

*Contingency Management (select one): ☐ Virtual Nonmonetary Rewards ☐ Digital Monetary Gift Card Rewards

DIAGNOSIS

Diagnosis: _____

*Primary ICD-10 Code: _____

Secondary ICD-10 Code: _____

☐ **If primary diagnosis is alcohol use disorder (AUD), check here for additional substance use and indicate a secondary ICD-10 code.**

Previous Treatments Tried and Failed:

☐ Inpatient treatment
☐ Intensive outpatient therapy
☐ Outpatient therapy at _____ (Insert facility)
☐ Attends/attended NA or AA meetings
☐ Outpatient group therapy
☐ Drug and alcohol counseling
☐ Medication-assisted treatment
☐ Other, please specify: _____

PRESCRIPTION

SELECT reSET® OR reSET-O®

☐ ***reSET** 12-week digital therapy
Complete therapy lessons as directed

DISPENSE: One access code good for 90-day therapy

OR

☐ ***reSET-O** 12-week digital therapy
Complete therapy lessons as directed

DISPENSE: One access code good for 84-day therapy

☐ *Confirm patient is taking buprenorphine.

LICENSED CLINICIAN ATTESTATION:

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By completing this form, I certify that my patient is aware of the disclosure of their personal health information to Pear Therapeutics, Sandoz and their business partners for reSET Connect patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product. I further certify that (a) any service provided through reSET Connect on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use reSET or any other Pear Therapeutics or Sandoz product or service for anyone, and (b) my decision to prescribe reSET was based solely on my determination of medical necessity as set forth herein, and that (c) if my patient is covered by a government insurance plan I will not seek reimbursement for services specifically related to reSET or reSET-O unless and until insurance coverage is finally determined.

*Licensed Clinician Signature: _____ *Date: _____

*Licensed Clinician Name Printed: _____

Patient Authorization I give permission for my health care providers (HCPs), pharmacy, health insurer(s), third party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Pear Therapeutics, Sandoz, and reSET Connect, their affiliates, business partners, and agents (referred together as "reSET Connect") so that reSET Connect can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with reSET, (ii) coordinate my receipt of and payment for reSET, (iii) facilitate my access to reSET, (iv) support me and provide me with information about reSET and my module completion, disease awareness, management programs, and educational materials, (v) manage the reSET Patient Service Center, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with the reSET Patient Service Center, and (viii) to send me information about programs that might help me pay for my reSET therapy, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for my reSET therapy, government agencies, and insurance companies for purposes of providing or facilitating this assistance. I give permission to reSET Connect to disclose my Personal Information to my pharmacy, health care providers, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to reSET Connect to combine or aggregate any information collected from me with information reSET Connect may collect about me from other sources for the purpose of providing or administering all necessary and important patient services. I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from reSET Connect in exchange for disclosing my personal information to reSET Connect and/or for providing me with therapy support services. I understand that once my Personal Information is disclosed it may no longer be protected by federal and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to reSET at any time in the future by calling 1-833-MY-RESET (1-833-697-3738) or by emailing us at PearConnect@PearTherapeutics.com. My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in reSET Connect. If I revoke this authorization, reSET Connect will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. 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 reSET Connect may change or end at any time without prior notification. I understand that I may receive a copy of this authorization. I agree to be contacted by reSET Connect by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Enrollment Form for all purposes described in this Patient Authorization. I also agree to be contacted by reSET Connect and others on its behalf by telephone calls, emails, and text messages, made by or using an automatic telephone dialing system or pre-recorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys. I con rm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify reSET Connect promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that reSET Connect does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing and non-marketing calls and texts from and on behalf of reSET Connect, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections; average of 3 to 10 messages per week. Message and data rates may apply. Privacy Policy at www.sandoz.com/privacy-policy. Text STOP to opt out and HELP for help.

Copay Assistance Program Terms and Conditions

Patients who are enrolled in any way in a Government program (including but not limited to Medicare, Medicaid, VA, DoD, and TRICARE) are not eligible for the Copay/Co-Insurance Assistance Program. Patients who are residents of the following states are not eligible for the Copay/Co-Insurance Assistance Program offers: (i) Patients who are residents of Massachusetts are not eligible for the Commercial Copay/Co-Insurance Assistance Program; (ii) Patients who are residents of Michigan, Minnesota, Missouri, Ohio and Rhode Island are eligible ONLY for the $15 Copay/Co-Insurance Assistance Program (i.e., the patient responsibility is $15); they are not eligible for the $0 Copay/Co-Insurance Assistance Program only at the point where they are eligible to receive Special Access (i.e., after commercial insurance coverage has been determined); (iii) Patients who are residents of states others than those identified above (i.e., Massachusetts, Michigan, Minnesota, Missouri, Ohio and Rhode Island) are eligible for the $0 Copay/Co-Insurance Assistance Program (i.e., the patient responsibility is $0).