reSET® reSET-O™

# PATIENT ENROLLMENT FORM

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
☐ Okay to receive reSET Connect text messages

☐ Okay to leave a reSET Connect voicemail
☐ Okay to receive reSET Connect text messages

## DEVICE

☐ iPhone ☐ Android

**CANNOT PROCESS FORM WITHOUT THIS COMPLETED**

**X** ______________________________

**Patient/Legal Guardian Signature**

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

______ / ______ / ______

**Date of Signature (MM/DD/YYYY)**

☐ I have read and agree to the Terms and Conditions for participation in the reSET Co-Pay Assistance Program on page 4.

☐ I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) consent on page 4 (optional).

☐ I have read and agree to the Fair Credit Reporting Act Authorization on page 4 (optional).

## INSURANCE

**Please include a copy (front & back) of all insurance cards.**

Does the patient have any form of health insurance? ☐ Yes ☐ No

Does the patient have government subsidized healthcare insurance (e.g., Medicare, Medicaid, Medigap, VA, DoD, or TRICARE)? ☐ Yes ☐ No

*Primary Plan Name: ______________________________

*Phone: ______________________________

*Member ID: ______________________________

*Group #: ______________________________

*Cardholder Name: ______________________________

*Relationship to Cardholder:

☐ Self ☐ Spouse ☐ Child ☐ Other

If applicable, complete required fields.

*Secondary Plan Name: ______________________________

*Phone: ______________________________

*Member ID: ______________________________

*Group #: ______________________________

*Cardholder Name: ______________________________

*Relationship to Cardholder:

☐ Self ☐ Spouse ☐ Child ☐ Other

For any questions, call 1-833-MY-RESET (1-833-697-3738)
or email us at PearConnect@PearTherapeutics.com.

PEAR THERAPEUTICS | SANDOZ A Novartis Division

# FOR OFFICE USE ONLY

Once all pages are completed, please fax to 877-256-1320.

* Indicates a required field.

## LICENSED CLINICIAN

*Name: ____________________

*Clinic/Practice: ____________________

*NPI #: ____________________

*Contact Person: ____________________

*Office Phone: ____________________

*Fax: ____________________

*Email: ____________________

*Cell Phone: ____________________

*Address: ____________________

Apt./Suite: __________ *City: ____________________

*State: __________ *ZIP: __________

## THERAPIST

Same as licensed clinician? ☐ Yes

*Name: ____________________

*Clinic/Practice: ____________________

NPI #: ____________________

Contact Person: ____________________

Office Phone: ____________________

Fax: ____________________

Email: ____________________

Cell Phone: ____________________

Address: ____________________

Apt./Suite: __________ *City: ____________________

State: __________ ZIP: __________

*Contingency Management (select one): ☐ Virtual Non-monetary Rewards ☐ Digital Monetary Gift Card Rewards

For digital monetary gift card rewards, which vendor is preferred? ☐ Amazon ☐ Starbucks ☐ Patient's Choice

## DIAGNOSIS

*Diagnosis: ____________________

*Primary ICD-10 Code: V ____________________

Secondary ICD-10 Code: V ____________________

☐ **If primary diagnosis is alcohol use disorder (AUD), check here for additional substance use.**

*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

☐ ***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 attest that I have obtained written permission from the patient and/or the patient's legal guardian to release the patient's protected health information to reSET Connect™ Patient Service Center (referred to collectively as "reSET Connect") as needed. I authorize EnvoyHealth Management, LLC to provide all applicable information on this form to the patient's insurer. This information is disclosed to verify insurance coverage for reSET or reSET-O, provide insurance reimbursement support, and confirm eligibility for patient assistance, as well as for other reasons listed on the Patient Authorization. I confirm that reSET Connect may contact me to obtain additional information in regard to the prescription information on the form, the therapy, and reSET Connect.
I further attest that my patient is not covered by a government insurance plan, and I will not seek reimbursement for services related to reSET or reSET-O for my patient 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 reSET Connect, its affiliates, business partners, and agents, as well as Envoy Health Management LLC ("EnvoyHealth") and its affiliates, business partners, and agents and any of reSET Connect's other designated patient service providers, (referred to collectively 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 confirm 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.

Continued on next page.

**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).

**reSET Connect and Fair Credit Reporting Act (FCRA) Authorization**

I understand that I am providing "written instructions" authorizing reSET Connect and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by reSET Connect. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call reSET Connect at 1-833-MY-RESET. If eligible, I would like to be considered for programs administered by reSET Connect.

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