PATIENT ENROLLMENT FORM

reSET / reSET-O

Phone: 1-833-697-3738 • Fax: 1-877-256-1320
Email: PearConnect@PearTherapeutics.com
Hours of Operation: Monday through Friday, 8 AM - 8 PM 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: _____ Last four digits of SSN: ___ ___ ___ ___ *Email: _____

*Address (no PO Box): _____ Apt/Suite: _____

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

*Cell Phone: _____ Alt Phone: _____

Preferred Contact Method: ☐ Phone ☐ Email Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

I authorize PearConnect™ 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 PearConnect. I also understand that, if others have access to my voicemail, there is a possibility that they may hear a message left by PearConnect.

X _____
Patient/Legal Guardian Signature

▶ PATIENT AUTHORIZATION (MANDATORY)

Please read the authorization for use and disclosure of health and other personal information on the back of this form. By signing below, I acknowledge that I have read and agree to the Patient Authorization on page 3.

X _____
Patient/Legal Guardian Signature

Date of Signature (MM/DD/YYYY): ____ / ____ / ____

INSURANCE

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

☐ **Patient is uninsured (Proceed to the Physician Authorization)**

*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: _____

_____
Clinic/Practice

PEAR CONNECT™ BY PEAR THERAPEUTICS

Patient Name

reSET / reSET-O

* Indicates a required field.

PHYSICIAN

LICENSED CLINICIAN

*Prescriber Name:

*NPI:

*Email:

*Clinic/Practice:

*Address:

Apt/Suite: City:

State: ZIP:

Office Contact Person:

Email:

Office Phone:

Office Fax:

ADDITIONAL CLINICIAN OR THERAPIST (OPTIONAL)

☐ N/A

*Name:

NPI:

*Email:

*Clinic/Practice:

*Address:

Apt/Suite: City:

State: ZIP:

Office Contact Person:

Email:

Office Phone:

Office Fax:

*Contingency Management (select one): ☐ Virtual Non-monetary 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 Refills:

OR

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

DISPENSE: One access code good for 84-day therapy Refills:

☐ *Confirm patient is taking buprenorphone.

The duration of the prescriptions is 12 weeks. Additional 12-week access intervals to reSET or reSET-O may benefit patients, as SUD and OUD are chronic diseases; however, the benefits of prescription extension have not been evaluated. The long-term benefit of treatment with reSET on abstinence has not been evaluated in studies lasting beyond 12 weeks in the SUD population. The ability of reSET to prevent potential relapse after treatment discontinuation has not been studied. The long-term benefit of using reSET-O has not been evaluated in studies with buprenorphine lasting beyond 12-weeks (84 days) in the OUD population. The ability of reSET-O to prevent potential relapse after treatment discontinuation has not been studied.

▶ PRESCRIBER AUTHORIZATION (MANDATORY):

I authorize PearConnect™ on behalf of my patient to furnish any information on this form to the insurer of the above-named patient and to send the access code for reSET or reSET-O to the above-named patient. I certify that the rationale for prescribing reSET or reSET-O is the following, based on my selection above in the Prescription box:

If reSET – to provide cognitive behavioral therapy, as an adjunct to a contingency management system, for patients 18 years of age and older who are currently enrolled in outpatient treatment for substance use disorder (SUD) under the supervision of a clinician to increase abstinence from a patient's substances of abuse during treatment, and increase retention in the outpatient treatment program. See Directions for Use for full safety information.

If reSET-O – to increase patient's adherence to outpatient treatment for opioid use disorder (OUD) by providing cognitive behavioral therapy, as an adjunct to outpatient treatment that includes transmucosal buprenorphine and contingency management, for patients 18 years of age or older who are currently under the supervision of a clinician. See Directions for Use for full safety information.

By my signature I also acknowledge that I have obtained the patient's authorization or consent, as necessary, to release the above information and such other information as may be required by PearConnect.

X _____

***Licensed Clinician Signature**

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

X _____

***Licensed Clinician Name Printed**

PEAR CONNECT™ BY PEAR THERAPEUTICS

PATIENT ENROLLMENT FORM

reSET® / reSET-O®

PATIENT AUTHORIZATION:

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my Protected Health Information ("PHI"), including but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to Pear Therapeutics, Inc. and its representatives, agents, and contracted third parties (together "PearConnect™"), to only be used for the following:

Providing my treating physician, as identified on this form, necessary PHI from my prescribing physician to facilitate my access to reSET® or reSET-O®

Providing reimbursement support associated with the filling of my prescription for reSET or reSET-O, including the performance of a preliminary insurance verification and the securing of any insurance coverage for reSET or reSET-O to which I am entitled.

Facilitating the provision of patient assistance, reduced cost medication and/or other reSET or reSET-O-related services offered by PearConnect. Facilitating my access to reSET or reSET-O, by providing me with information about reSET or reSET-O and my module completion, disease awareness, management programs, and educational materials.

Providing me with adherence reminders and support.

Conducting quality assurance, surveys, and other internal business activities in connection with PearConnect.

Improving the overall patient experience from enrollment to use of reSET or reSET-O and for analyses and in publications, provided that my information is aggregated with other data and does not contain any personal identifying information.

By signing this authorization, I authorize PearConnect to disclose my PHI, including but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription, in addition to household income and size, to my health plans, physicians, and pharmacy providers, Envoy Health Management, LLC, Diplomat Pharmacy, Inc., Experian Health, and certain other third-party contractors and their representatives, agents, and contracted third parties to only be used for the following:

Providing my treating physician, as identified on this form, necessary PHI from my prescribing physician to facilitate my access to reSET or reSET-O

Providing reimbursement support associated with the filling of my prescription for reSET or reSET-O, including the performance of a preliminary insurance verification and the securing of any insurance coverage for reSET or reSET-O to which I am entitled. Participation in any Pear program is voluntary and you must meet eligibility requirements. You may be required to provide documentation regarding your insurance coverage, if it exists, household income and US residency.

Facilitating the provision of patient assistance, reduced cost medication and/or other reSET or reSET-O-related services offered by PearConnect. Facilitating my access to reSET or reSET-O, by providing me with information about reSET or reSET-O and my module completion, disease awareness, management programs, and educational materials.

Providing me with adherence reminders and support.

Conducting quality assurance, surveys, and other internal business activities in connection with the PearConnect.

Improving the overall patient experience from enrollment to use of reSET or reSET-O and for analyses and in publications, provided that my information is aggregated with other data and does not contain any personal identifying information.

Providing information technology support that may require access to my PHI.

By signing this form, I understand that once my health plans, physicians, and pharmacy providers, or PearConnect, have disclosed my PHI to the parties specified herein, that information may no longer be protected by certain federal and state privacy laws, although certain other federal protections may apply. PearConnect agrees to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law, and to notify other parties to whom PearConnect discloses the information of PearConnect's obligation to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law. I understand that I may refuse to sign this authorization and that my health plans, physicians, and pharmacy providers will not condition treatment, payment, or eligibility for benefits on my signing this authorization, but that if I do not sign this authorization, I will not be able to obtain PearConnect services. I understand that I am entitled to a copy of this authorization. I also may revoke (cancel) this authorization at any time in the future by calling 1-833-697-3738 or by emailing PearConnect@PearTherapeutics.com, but that this cancellation will not apply to any information already used or disclosed in reliance on this authorization before notice of the cancellation is received by my health plans, physicians, and pharmacy providers, or PearConnect. I also understand that PearConnect will no longer be able to provide me with services if I cancel my authorization. I authorize PearConnect and its healthcare partners to forward the prescription provided by my physician, by fax or by another mode of delivery, to the pharmacy. I understand that this authorization will remain valid for seven (7) years after the date of my signature, unless applicable law requires an earlier expiration or I revoke my authorization earlier. I also understand that the services offered by PearConnect may change or end at any time without prior notification.

I authorize PearConnect to provide me with support services related to any Pear products, including, but not limited to: educational support provided in-person, online, or by telephone; financial assistance services; and product support services; as well as any information or materials related to such services. I authorize PearConnect to contact me to provide such services and information by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone-dialing system or a prerecorded voice) (average of 3-10 messages per week) (standard message and data rates may apply; I may opt out at any time by sending an e-mail with subject line "STOP" to PearConnect@PearTherapeutics.com and I understand that I am not able to opt out by directly replying to any text message). I also authorize the disclosure of my personal health information to specific individuals that I have designated.

Please find more information on reSET-O at https://peartherapeutics.com/reset-o-pt-privacy/ and https://peartherapeutics.com/reset-o-pt-terms/. Please find more information on reSET at https://peartherapeutics.com/reset-pt-privacy/ and https://peartherapeutics.com/reset-pt-terms/.

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 or the $15 Copay/Co-Insurance Assistance Program; (ii) Patients who are residents of Michigan, Minnesota, Missouri 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 there 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, Missouri and Rhode Island) are eligible for the $0 Copay/Co-Insurance Assistance Program (i.e., the patient responsibility is $0).

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