IPSEN CARES™ ENROLLMENT FORM

Information and Insurance Verification

Fax: 1-888-525-2416 | Phone: 1-866-435-5677

Physician Information

Physician Name **(first and last name)** ______________________

Practice/Facility Name ______________________

Specialty ❑ Neurology ❑ Physiatry ❑ Other ________ Medical Education # ______________________

Street Address ______________________ City ______________________

State ________ ZIP ________ Phone # ________ Fax # ________

DEA # ________ PTAN # ________ NPI # ________ LIC # ________ Tax ID # ________

Office Contact Name ______________________ Phone # ________ Fax # ________

Patient Information

Patient Name **(first and last name)** ______________________ Date of Birth ____/____/____ ❑ Male ❑ Female

Street Address ______________________ City ______________________

State ________ ZIP ________ Phone # ________ Fax # ________

Treatment Information

Site of Service ❑ Physician's Office ❑ Hospital Outpatient ❑ Other ________

Prior Therapy ❑ Physical Therapy ❑ Other Botulinum Toxin Type A ❑ Other ________

Diagnosis Code 1 **(required)** ________ EMG Code ________ CPT Code ________ HCPCS ________

Diagnosis Code 2 ________ Date of Service **(if scheduled)** ________

Dysport Dose ________ Units Injection Sites ______________________

Insurance Information – PRIMARY

(You can submit a copy of the patient's insurance card; attach copy, front and back, instead of completing this section.)

❑ Medicare ❑ Medicaid ❑ Commercial ❑ Workers' Compensation ❑ TRICARE ❑ VA

Name of Insurance Company ______________________

Phone # ______________________ Fax # ______________________

Subscriber's Name ______________________ Policy # ________ Group # ________

Subscriber's DOB ____/ ____/ ____ Employer's Name ______________________

Subscriber's ID # ________ Employer's Addres ______________________

Relationship to Patient ________ Is Physician a Participating Provider (check one)? ❑ Participating ❑ Non-Participating

Insurance Information – SECONDARY

(You can submit a copy of the patient's insurance card; attach copy, front and back, instead of completing this section.)

❑ Medicare ❑ Medicaid ❑ Commercial ❑ Workers' Compensation ❑ TRICARE ❑ VA

Secondary Insurance Name ______________________ Phone # ______________________

Subscriber's Name ______________________ ID # ________ Group # ________

PRESCRIBER/OFFICE MANAGER ATTESTATION: (The Prescriber must sign if this form is to be used as a prescription to be triaged to a Specialty Pharmacy or to enroll a patient for free goods as part of the Patient Assistance Program (PAP). The office manager of the Prescriber may sign if the request is limited to Benefit Verification or Copay Assistance Support.)

By signing below, I certify that a prescription signed by a licensed prescriber is on file or provided above for the above therapy and that the patient has provided the necessary authorization to release the above referenced information and medical and/or patient information relating to Dysport® therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for Dysport® therapy, assisting in initiating or continuing Dysport® therapy, and/or evaluating the patient's eligibility for Ipsen's patient support programs administered by IPSEN CARES™.

These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. If named patient does not return for therapy, product will be returned to Ipsen. I acknowledge that I have assisted the patient in enrolling in IPSEN CARES™ exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

FOR PRESCRIBER ONLY: I authorize Ipsen to be my agent and to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the above-named patient. For the state of New York, copies of all prescriptions should be on official New York state prescription forms. I certify that any medications received from Ipsen in connection with any IPSEN CARES™ program will be used only for the patient named on this form.

Name ______________________ Title ______________________

Signature ______________________ Date ______________________

Please Click Here for Full Prescribing Information, including **Boxed Warning** and Medication Guide.

Questions?

To request a visit from your Dysport® Field Reimbursement Manager, email reimbursementinformation@ipsen.com.

PATIENT AUTHORIZATION

Fax: 1-888-525-2416 | Phone: 1-866-435-5677

Patient Authorization to Use/Disclose Health Information: IPSEN CARES™ Program

I authorize my/the patient's healthcare providers (including those pharmacies that may receive my prescription for Dysport®) to disclose personal health information (PHI) about me/the patient, including health information relating to my/the patient's medical condition, treatment, and insurance coverage, to Ipsen Biopharmaceuticals, Inc., its affiliates, and its agents that have been hired to administer the Ipsen Coverage, Access, Reimbursement & Education Support (IPSEN CARES™) program on its behalf (collectively "Ipsen") in order for Ipsen to: (1) enroll me/the patient in IPSEN CARES™; (2) establish my/the patient's benefit eligibility and potential out-of-pocket costs for Dysport®; (3) communicate with my/the patient's healthcare providers and health plans about my/the patient's treatment plan; (4) provide support services, including patient education and financial assistance for Dysport®; (5) help get Dysport® shipped to my/the patient's healthcare provider; and (6)facilitate my/the patient's participation in Dysport® patients programs as I have requested or may request. I agree that, using the contact information I provide, Ipsen may get in touch with me for reasons related to the IPSEN CARES™ program and support services and may leave messages for me that may disclose that I/the patient am on Dysport® therapy. I consent to being contacted by an IPSEN CARES™ program representative in order for the program to obtain further information or clarification regarding any adverse event I/the patient may experience. Similarly, I consent to a program representative contacting my/the patient's doctor or other healthcare professional for the same purpose.

I understand that once my/the patient's PHI has been disclosed to Ipsen, privacy laws may no longer restrict its use or disclosure; however, Ipsen agrees to protect my/the patient's information by using and disclosing it only for the purposes described above or as required by law. I understand that my/the patient's healthcare providers may receive remuneration from Ipsen in exchange for my/the patient's PHI and/or for any therapy support services provided to me/the patient. I can withdraw this authorization by calling IPSEN CARES™ at 1-866-435-5677 or mailing a letter requesting such revocation to IPSEN CARES™, 11800 Weston Parkway, Cary, NC 27513, but it will not change any actions taken before I withdraw authorization. Withdrawal of authorization will end further uses and disclosures of PHI by the parties identified in this form except to the extent those uses and disclosures have been made in reliance upon my authorization. I understand that I may refuse to sign this form and, if I do so, I/the patient will not be able to participate in IPSEN CARES™ programs, but it will not affect my/the patient's eligibility to obtain medical treatment, my/the patient's ability to seek payment for this treatment or affect my/the patient's insurance enrollment or eligibility for insurance coverage. This authorization expires one year after the date I sign it below. I understand that I will receive a copy of the signed authorization.

Patient Name ______________________ Parent/Legal Guardian Name ______________________

Relationship to Patient ______________________

Signature ______________________ Date ______________________

Patient Date of Birth ______________________ Patient Phone Number ______________________

Additional Support and Patient Program Participation

In addition to participating in the IPSEN CARES™ program described above, I authorize the disclosure of personal health information (PHI) about me, including health information relating to my medical condition, treatment, and insurance coverage, to Ipsen, its affiliates, and its agents in order for Ipsen to:

- ❑ Evaluate the effectiveness of Ipsen's patient support programs and conduct market analysis, including aggregating my PHI with other data for such analysis and solicit my opinions about IPSEN CARES™ services.
- ❑ Provide information to me, which may include marketing and educational material about Dysport® and relevant disease state programs that support patients.
- ❑ Solicit my opinions regarding Dysport® and Ipsen's products and services and market research.

I understand that I do not have to sign this section of the form in order to participate in the IPSEN CARES™ program and that I may revoke my authorization to receive additional product information at any time. By signing below, I agree that Ipsen and its agents may use and disclose my personal information (including name, address, phone number, and/or email of the parent/caregiver) to provide these services. I understand that my cell phone carrier's standard rates may apply for calls to my cell phone. This authorization is valid for one year after signature. I may revoke this authorization by calling 1-866-435-5677 or by sending a request in writing to IPSEN CARES™, 11800 Weston Parkway, Cary, NC 27513.

I understand that I do not have to sign this section of the form in order to participate in the IPSEN CARES™ program and that I may revoke my authorization to receive additional support and product information at any time. This authorization is valid for one year after signature.

To revoke this authorization, please call 1-866-435-5677 or send your request in writing to: IPSEN CARES™, 11800 Weston Parkway, Cary, NC 27513.

Patient Name ______________________ Parent/Legal Guardian Name ______________________

Relationship to Patient ______________________

Signature ______________________ Date ______________________

www.ipsencares.com

Dysport®(abobotulinumtoxinA) for injection, for intramuscular use, 500-unit vial
Dysport is a registered trademark of Ipsen Biopharm Limited.
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