PATIENT AUTHORIZATION

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

Dysport® (abobotulinumtoxinA)

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 _____

Questions? Call IPSEN CARES at 1-866-435-5677 **www.ipsencares.com**

IPSEN CARES™
Coverage, Access, Reimbursement & Education Support