

IPSEN CARES® ENROLLMENT FORM

Information and Insurance Verification

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



Form 1 of 2

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 # _____

Prescription and 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 Address _____
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.

Prescriber Name _____ Prescriber Title: _____
Prescriber 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.



Dysport[®]
(abobotulinumtoxinA)

PATIENT AUTHORIZATION

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



Form **2** of 2

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

Patient/parent/caregiver agrees to be contacted by autodialed text messages ("texts") at the mobile phone number patient/parent/caregiver provided for the purpose of helping the patient stay on therapy. Patient/parent/caregiver may opt out of individual communications of the program entirely at any time by calling 866-435-5677 or replying "STOP" by text to the number patient/parent/caregiver receives texts from. Ipsen will not sell or rent patient/parent/caregiver's information and will only use this information in accordance with this authorization and patient/parent/caregiver's consent. Consent to being contacted by text messages is not a condition of participation in the IPSEN CARES® programs or the purchase of any products. Patient/parent/caregiver understands that cellular service carrier's data and text messaging rates may apply. Privacy policy at www.ipsencares.com. This authorization is valid for one year from the date patient/parent/caregiver signs the form.

In addition to participating in the IPSEN CARES® program above, patient/parent/caregiver would also like to receive information from Ipsen, which may include marketing and educational material about Dysport® and programs that support patients. Patient/parent/caregiver understands that patient/parent/caregiver does not have to sign this section of the form in order to participate in the IPSEN CARES® program and that may revoke this authorization to receive additional product information at any time. By signing below, patient/parent/caregiver agrees that Ipsen and its agents may use and disclose patient/parent/caregiver's personal information (including name, address, phone number, and/or email of the patient/parent/caregiver) to provide these services and Ipsen may also contact patient/parent/caregiver to solicit patient/parent/caregiver's opinions regarding Dysport® and Ipsen's products and services. Patient/parent/caregiver understands that patient/parent/caregiver's cell phone carrier's standard rates may apply for calls to patient/parent/caregiver's cell phone. This authorization is valid for one year from the date patient/parent/caregiver signs the form. Patient/parent/caregiver may revoke this authorization by calling 866-435-5677 or sending a request in writing to: IPSEN CARES®, 11800 Weston Parkway, Cary, NC 27513.

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

Please [click here](#) for Full Prescribing Information, including **Boxed Warning** and Medication Guide.

IPSEN CARES®
Coverage, Access, Reimbursement & Education Support



Dysport[®]
(abobotulinumtoxinA)