PATIENT ASSISTANCE PROGRAM APPLICATION

Dysport® (abobotulinumtoxinA)

Fax Completed Form To:

1-888-525-2416

The Patient Assistance Program (PAP) is designed to provide Dysport® (abobotulinumtoxinA) at no cost to eligible patients. Patients may be eligible to receive free drug if they are experiencing financial hardship, have no insurance coverage, and received a prescription for an on-label use of Dysport, as supported by information provided in the Program application. Eligibility does not guarantee approval for participation in the program. The PAP provides Dysport product only, and does not cover the cost of previously purchased product or medical services.

Instructions: Both the patient and the healthcare provider have to complete the application.

PATIENT REQUIREMENTS

- Complete and sign the Patient Information section, including the Financial Information section.
- If you are seeking financial assistance from the PAP, please fax a copy of proof of total household income. Accepted forms include most recently filed Federal Tax Forms (i.e., Form 1040) including supporting documents (W-2), social security income (SSA 1099), or the completed Income Statement form included at the end of this application.

HEALTHCARE PROVIDER REQUIREMENTS

- Complete and sign the Healthcare Provider Information section.
- Verify that the patient is being prescribed and administered Dysport.
- Ensure the entire application is complete and signed before sending it to the fax number provided above.

It is important that you and your healthcare provider complete all requested information and sign where indicated. Since incomplete or incorrect applications will delay the application process, please ensure all information provided is correct.

We recommend that you fax the completed form in order to expedite the process. Once the application is received, we will evaluate the patient's eligibility to participate in the PAP. Healthcare providers will be notified upon completion of eligibility review. Please note that program rules are subject to change without notice. For further assistance, please call 1-866-435-5677 from 8:00 AM to 8:00 PM ET, Monday through Friday.

Sincerely,

The IPSEN Coverage, Access, Reimbursement & Education Support (CARES) program

Please fill in the required information on the next 3 pages and fax the completed form to 1-888-525-2416.

Please see accompanying full Prescribing Information, including **Boxed Warning** and Medication Guide, also available at **www.dysport.com.**

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PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE PATIENT

First Name _____ MI _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____/_____/_____

Mailing Address _____ Apt # _____

City _____ State _____ Zip _____

Social Security Number _____ Gender ☐ Male ☐ Female

Daytime Phone Number (____) _____ Evening Phone Number (____) _____

Email Address _____ Are you a US resident? ☐ Yes ☐ No

Physician _____ Treating Facility _____

PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

My estimated annual household income currently is $_____

(Please include dollar amount of monthly income from)

$_____ Social Security Disability Income (SSDI) (beginning _____ /_____)

$_____ Supplemental Security Income (SSI)

$_____ Aid from the Department of Public Welfare

$_____ Unemployment Benefits (from _____ /_____ to _____ /_____)

$_____ Workers Compensation Benefits (from _____ /_____ to _____ /_____)

$_____ Dividends, interest, or investment accounts

$_____ Employment (myself and/or my spouse)

$_____ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household _____

Insurance Type	Status	Effective Date	Please indicate Primary (P) or Secondary (S)
Commercial	☐ Approved ☐ Denied ☐ Waiting for Decision	_____/_____/_____	
Medicaid	☐ Approved ☐ Denied ☐ Waiting for Decision	_____/_____/_____	
Medicare	☐ Approved ☐ Denied ☐ Waiting for Decision	_____/_____/_____	
TriCare	☐ Approved ☐ Denied ☐ Waiting for Decision	_____/_____/_____	
Healthcare Exchange	☐ Approved ☐ Denied ☐ Waiting for Decision	_____/_____/_____	
Other	☐ Approved ☐ Denied ☐ Waiting for Decision	_____/_____/_____	
☐ Uninsured	Patient is not eligible for any public health insurance, which includes Medicare and Medicaid, or has been denied coverage by a third-party payer.		

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PATIENT INFORMATION (CONTINUED): THIS SECTION TO BE COMPLETED BY THE PATIENT

I authorize my/the patient's doctor(s) and their staff to disclose my/the patient's personal health information ("PHI"), including information about my/the patient's insurance, prescription, and medical condition to Ipsen Biopharmaceuticals, Inc., and/or its agents or third party vendors (collectively, "Ipsen") and the Dysport Patient Assistance Program (the "PAP"). I know that the information I provide will be used by the PAP to: (1) decide if I/the patient am/is eligible for assistance; (2) operate the PAP; (3) send me information about the PAP and other programs that might help me pay for my/the patient's medicines; (4) send my/the patient's information to other programs that might help me pay for my/the patient's medicines; (5) ask me for financial, insurance, and/or medical information; and/or (6) share my/the patient's information as required or permitted by law. I authorize the PAP to use information on this Application and any other information I give to the PAP for these same reasons. I also give Ipsen permission to share my/the patient's PHI and other information with people and companies that work with the PAP; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my/the patient's doctor(s) and other people, or institutions who are involved in my/the patient's healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for my/the patient's medication. All information that I provide may be used by Ipsen, or any third party working on behalf of Ipsen, in connection with the PAP. I understand that once my/the patient's PHI has been disclosed to Ipsen, it is no longer protected by federal privacy laws and Ipsen may re-disclose it; however, Ipsen has agreed to protect my/the patient's PHI by using and disclosing it only for the purposes described above or as required by law. I can withdraw this authorization by contacting "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 this authorization. Withdrawal of this 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 this 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 the PAP, 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.

I promise that any information, including financial and insurance information, that I provide to the PAP is complete and true, and unless I have said something different in this application, I have no insurance coverage for this product, 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 notify IPSEN CARES at 1-866-435-5677. I understand that Ipsen has the right to contact me directly to confirm receipt of medications. Ipsen may revise, change, or terminate this program at any time.

Patient/Legal Guardian Signature _____ Date _____

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HEALTHCARE PROVIDER INFORMATION: THIS SECTION MUST BE COMPLETED BY THE PRESCRIBING PHYSICIAN

Prescriber Name _____ Street Address _____

DEA# _____ State license # _____

Tax ID # _____ NPI# _____ City _____ State _____ Zip _____

Medicaid provider # _____ Office contact and title _____

Medicare PTAN # _____ Phone (____) _____ Fax (____) _____

Office/Institution _____ Email Address _____

Specialty _____ Preferred method of contact ☐ Phone ☐ Fax

PRESCRIBER ATTESTATION: (The Prescriber must sign if this form is to be used as a prescription to be triaged to a Specialty Pharmacy, request for Injection Training, request for Home Health Administration (HHA) 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 for the above therapy and that the patient named on this form 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®. 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 patient named on this form. 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 named patient.

These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to any payor, including Medicare, Medicaid, or any other federal or state health insurance program, nor will any medications be returned for credit. If the 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.

Prescriber Signature _____ Date _____

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