

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, prescription, 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 contact 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.

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 _____

www.ipsencares.com

ADDITIONAL SUPPORT

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

Additional Support and Patient Program Participation

I agree to be contacted by autodialed text messages (“texts”) at the mobile phone number I have provided below for the purpose of helping me/the patient stay on therapy, which may promote or advertise the Ipsen products included in the therapy plan. I certify that the number I am providing belongs to me and not a family member or third party. I understand that I may opt out of individual communications of the program entirely at any time by calling 866-435-5677 or replying “STOP” by text to any text from Ipsen. Ipsen will not sell or rent this information and will use it only in accordance with this authorization and 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 or services. I understand that my 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 the form is signed. If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Ipsen harmless in the event that such other person alleges that they did not give consent.

In addition to participating in the IPSEN CARES program above, I would also like to receive information from Ipsen via text message and voice call, all of which may include telemarketing, advertisements, and educational material about DYSPORT and programs that support patients. These text messages and voice calls may be made via the use of automatic telephone dialing systems. I certify that the number I am providing belongs to me and not to a family member or other third party. 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 this 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) to provide these services and Ipsen may also contact me to solicit my opinions regarding DYSPORT and Ipsen’s products and 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 from the date the form is signed. I may revoke this authorization, by calling 866-435-5677 or sending a request in writing to: IPSEN CARES, 11800 Weston Parkway, Cary, NC 27513. If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Ipsen harmless in the event that such other person alleges that they did not give consent. 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 _____

Please see accompanying full [Prescribing Information](#), including **Boxed Warning** and [Medication Guide](#).