Please Fill Out Form Completely and Fax Back to 1-888-525-2416

increlex®
(mecasermin [rDNA origin] injection)

Patient Authorization

Please fax the signed form to IPSEN CARES® at the number above or send the form to:
IPSEN CARES® Program
Ipsen Biopharmaceuticals, Inc.
11800 Weston Parkway
Cary, NC 27513

Patient Authorization and Signature – IPSEN CARES® Program

I authorize my/the patient's healthcare providers (including those pharmacies that may receive my/the patient's prescription for INCRELEX®) 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 INCRELEX®; (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 INCRELEX®; (5) help get INCRELEX® shipped to me/the patient; and (6) facilitate my/the patient's participation in INCRELEX® patient 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 am/the patient is on INCRELEX® 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, 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 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.

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 Product and Support Information

☐ 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 me/my child/my dependent 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 INCRELEX® 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 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 INCRELEX® 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.

Patient Name: _____ Parent/Legal Guardian Name:* _____

Relationship to Patient: _____

Signature:_____Date: _____

* Please provide name of parent or legal guardian, if patient is under 18 years of age.

Please See Next Page for Important Safety Information Regarding INCRELEX®.

Who is INCRELEX® for?

INCRELEX® is used to treat children who are very short for their age because their bodies do not make enough IGF-1. This condition is called severe primary IGF-1 deficiency. INCRELEX® should not be used for other causes of growth failure and should not be used instead of growth hormone.

Important Safety Information

Who Should Not Use INCRELEX®

Your child should not take INCRELEX® if your child: has finished growing (the growth plates at the end of the bones are closed) has cancer, OR is allergic to mecasermin or any of the inactive ingredients in INCRELEX®. INCRELEX® has not been studied in children under 2 years of age and should never be used in newborns. **Your child should never receive INCRELEX® through a vein**.

Before your child takes INCRELEX®, you should tell your child's doctor about:

All of your child's health conditions, including: diabetes, kidney problems, liver problems, allergies, scoliosis (curved spine), pregnancy, or breast-feeding.

All the medicines (prescription and nonprescription), vitamins, and herbal supplements your child takes, especially insulin or other anti-diabetes medicines, which may require dose adjustments of these medicines.

What are possible side effects of INCRELEX® (some of which can be serious)?

Low blood sugar (hypoglycemia) Only give your child INCRELEX® right before or right after (20 minutes on either side of) a snack or meal to reduce the chances of hypoglycemia. Signs include dizziness, tiredness, restlessness, hunger, irritability, trouble concentrating, sweating, nausea, and fast or irregular heartbeat. Do not give your child INCRELEX® if your child is sick or cannot eat. Severe hypoglycemia may cause unconsciousness, seizures, or death. People taking INCRELEX® should avoid participating in high-risk activities (such as driving) within 2 to 3 hours after an INCRELEX® injection.

Allergic reactions Your child may have a mild or serious allergic reaction with INCRELEX®. Call your child's doctor right away if your child gets a rash or hives. If hives do occur, they generally appear minutes to hours after the injection as an itchy, raised skin reaction, pale in the middle with a red rim around them, and may sometimes occur at numerous places on the skin. Get medical help immediately if your child has trouble breathing or goes into shock, with symptoms like dizziness, pale, clammy skin, and/or passing out.

Increased pressure in the brain (intracranial hypertension) INCRELEX®, like growth hormone, can sometimes cause a temporary increase in pressure within the brain. Symptoms include persistent headache, blurred vision, and nausea with vomiting.

Enlarged tonsils Signs include: snoring, difficulty breathing or swallowing, sleep apnea (a condition where breathing stops briefly during sleep), or fluid in the middle ear.

A bone problem called slipped capital femoral epiphysis This happens when the top of the upper leg (femur) slips apart from the rest of the bone. Seek immediate medical attention if your child develops a limp or has hip or knee pain.

Worsened scoliosis (caused by rapid growth).

Injection site reactions including: swelling, loss of fat, increase of fat, pain, redness, or bruising. This can be avoided by changing/rotating the injection site with each injection.

Your child's doctor is your primary source of information about treatment. For more information, please talk to your doctor.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

For more information, please talk to your doctor or visit **www.ipsencares.com.**

Please See the Accompanying Patient Information.

increlex®
(mecasermin [rDNA origin] injection)