

Questions? Call IPSEN CARES® at 1-866-435-5677



## Patient Assistance Program Application

PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE PATIENT.

Fax Completed Form To:  
**1-888-525-2416**

The INCRELEX Patient Assistance Program (PAP) is designed to provide INCRELEX 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 Increlex, as supported by information provided in the Program application. Eligibility does not guarantee approval for participation in the program. The INCRELEX PAP provides INCRELEX (mecasermin) product only, and does not cover the cost of previously purchased product or medical services.

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

### **PATIENT/ GUARDIAN 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 INCRELEX.
- 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 INCRELEX 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.

Please see INCRELEX [Patient Information](#) and [Full Prescribing Information](#) also available at [www.increlex.com](http://www.increlex.com).

Sincerely,

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

**IPSEN CARES®**  
Coverage, Access, Reimbursement & Education Support



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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  
 Prescribing Physician \_\_\_\_\_ Treating Facility \_\_\_\_\_  
 Patient/Guardian name and relationship to patient \_\_\_\_\_

**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	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Waiting for Decision	____/____/____	
Medicaid	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Waiting for Decision	____/____/____	
Medicare	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Waiting for Decision	____/____/____	
TriCare	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Waiting for Decision	____/____/____	
Healthcare Exchange	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Waiting for Decision	____/____/____	
Other	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Waiting for Decision	____/____/____	
<input type="checkbox"/> 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

As parent and/or guardian of the patient, I authorize the patient's doctor(s) and their staff to disclose the patient's personal health information ("PHI"), including information about insurance, prescription, and medical condition to Ipsen Biopharmaceuticals, Inc. and/or its agents or third-party vendors (collectively, "Ipsen") and the Increlex Patient Assistance Program (the "PAP"). I know that the information I provide will be used by the PAP to: (1) decide if the patient is eligible for assistance; (2) operate the PAP; (3) send me information about the PAP and other programs that might help me pay for the patient's medicines; (4) send information to other programs that might help me pay for the patient's medicines; (5) ask me for financial, insurance, and/or medical information; and/or (6) share my information and 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 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; the patient's doctor(s) and other people, or institutions who are involved in the patient's healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for 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 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 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, the patient will not be able to participate in the PAP, but it will not affect the patient's eligibility to obtain medical treatment, the patient's ability to seek payment for this treatment or affect 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 insurance 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 Biopharmaceuticals, Inc., may revise, change, or terminate this program at any time.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**increlex**<sup>®</sup>  
(mecasermin) injection 10 mg

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

Prescriber Name \_\_\_\_\_  
DEA# \_\_\_\_\_ State license # \_\_\_\_\_  
Tax ID # \_\_\_\_\_ NPI# \_\_\_\_\_  
Medicaid provider # \_\_\_\_\_  
Medicare PTAN # \_\_\_\_\_  
 Speciality  Pediatrician  Endocrinologist  Other \_\_\_\_\_

Office contact and title \_\_\_\_\_  
Office/Institution \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_  
Preferred method of contact  Phone  Fax

**PRESCRIBER ATTESTATION**

By signing below, I certify that the above therapy is medically necessary and that I have received the necessary authorization to release the above referenced information and medical and/or patient information relating to INCRELEX therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for INCRELEX therapy, assisting in initiating or continuing INCRELEX 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 on behalf of 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 named 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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