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

# IPSEN CARES® Enrollment Form

onivyde® (irinotecan liposome injection)

Please print the form, fill it out completely, sign it, and

**FAX TO 1-888-525-2416**

To be completed by patient and physician's office.

☐ All IPSEN CARES Program Services ☐ Benefits Verification Only

## PATIENT

Patient Name (First & Last) _____

Patient Address _____

City _____ State _____ Zip ___

Caregiver/Alternate Contact Name _____

Relationship of Caregiver/Alternative Contact to Patient _____

Caregiver/Alternate Contact Phone # (____) _____

Date of Birth (MM/DD/YY) _____/_____ /_____ ☐ Male ☐ Female

Email Address _____

Home Phone # (____) _____ Other Phone # (____) _____

Preferred Language _____

## INSURANCE

Complete or attach front and back copy of patient's primary and secondary insurance cards for pharmacy and medical benefits.

Is patient insured? ☐ Yes ☐ No

Does patient have secondary insurance? ☐ Yes ☐ No

Pharmacy Insurance Co. _____

Insurance Co. Phone # (____) _____ Subscriber Policy ID # ____

Is Physician a Participating Provider (check one) ☐ Participating ☐ Non-Participating

Policy/Employer/Group # _____

Medical Insurance Co. _____

Insurance Co. Phone # (____) _____

Subscriber Name _____ Policy ID # _____

## PRESCRIBER

Prescriber Name _____

DEA # _____ State License # _____

Tax ID # _____ NPI # _____

Medicaid Provider # (Required if Medicaid Patient) _____

Medicare PTAN # (Required if Medicare Patient) _____

Office/Institution _____

Specialty ☐ Oncologist ☐ Endocrinologist ☐ Other _____

Street Address _____

City _____ State _____ Zip _____

Office Contact and Title _____

Phone # (____) _____ Fax # (____) _____

Email Address _____

Preferred Method of Contact ☐ Phone ☐ Fax

## PRESCRIPTION AND TREATMENT INFORMATION

**ONIVYDE® (irinotecan liposome) injection**

Diagnosis Code 1 **(required)** _____ EMG Code _____ CPT Code _____ HCPCS _____

Diagnosis Code 2 _____ Date of Service **(if scheduled)** _____

Strength _____ Frequency _____

Quantity _____ Number of Refills _____

**Route: Intravenous Injection (IV)**

Site of Care ☐ Physician Office ☐ Hospital/Outpatient ☐ Infusion Center ☐ Other _____

Directions for Use _____

## PRESCRIBER/OFFICE MANAGER ATTESTATION

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 ONIVYDE therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for ONIVYDE therapy, assisting in initiating or continuing ONIVYDE 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.

Name _____ Title _____

Signature _____ Date _____

Please see accompanying full Prescribing Information, including **BOXED WARNING.**

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Coverage, Access, Reimbursement & Education Support

Have you documented that your patient has experienced an inadequate response to or cannot be treated with surgery and/or radiotherapy?

☐ Yes ☐ No

Diagnosis (ICD-10-CM Code) _____ Description _____

CPT Code _____ Description _____

Date of Diagnosis _____/_____/_____ Therapy Start Date _____/_____/_____

Have other products been used to treat this patient? ☐ Yes ☐ No Product _____ Date of Last Injection _____/_____/_____

Allergies ☐ No Known Drug Allergies ☐ List Allergies _____

List Medications _____

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# PATIENT AUTHORIZATION

## Patient Authorization and Signature - IPSEN CARES Program

I authorize my healthcare providers (including those pharmacies that may receive my prescription for ONIVYDE®), to disclose personal health information ("PHI") about me, including health information relating to my 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 in IPSEN CARES; (2) establish my benefit eligibility and potential out-of-pocket costs for ONIVYDE ; (3) communicate with my healthcare providers and health plans about my treatment plan; (4) provide support services including patient education and financial assistance for ONIVYDE; (5) help get ONIVYDE shipped to me or my healthcare providers; (6) evaluate my eligibility for home health administration if requested by my physician; and (7) facilitate my participation in ONIVYDE patient programs that I have elected to receive information about, as indicated below. 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 am on ONIVYDE 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 may experience.

I understand that once my 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 PHI by using and disclosing it only for the purposes described above or as required by law. I understand that my healthcare providers may receive remuneration from Ipsen in exchange for my 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 will not be able to participate in IPSEN CARES programs, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my 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 _____ Caregiver _____

Name _____ Relationship to Patient _____

Signature _____ Date _____

Patient Date of Birth _____ Patient Phone Number _____

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## ADDITIONAL PRODUCT AND SUPPORT INFORMATION

☐ 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 ONIVYDE 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 ONIVYDE 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.

Patient Name_____ Caregiver _____

Name _____ Relationship to Patient_____

Signature _____ Date_____

Please see accompanying full Prescribing Information, including **BOXED WARNING.**



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