Dysport® (abobotulinumtoxinA)

IPSEN CARES®
Coverage, Access, Reimbursement & Education Support

Member Reimbursement Form

The IPSEN CARES® Copay Assistance Program Member Reimbursement Form may only be completed by the patient or the patient's authorized representative. This form is for patients who have already been enrolled in the IPSEN CARES program; if you are not enrolled in IPSEN CARES, visit https://copay.ipsencares.com/dysport/ to enroll. The form should be submitted along with all required documentation to request reimbursement for out-of-pocket expenses the patient has paid toward the cost of Dysport®, in accordance with the Terms and Conditions* of the IPSEN CARES Copay Assistance Program.

Please note that the patient is responsible for any costs not covered by the program.

For questions about submitting this claim, the patient or their authorized representative may contact IPSEN CARES Support at 1-866-435-5677.

How to Submit Your Reimbursement Request:

1 Complete the Form

a. Fill out Sections A, B, and C.
b. Sign and date Section D.

2 Include Your Explanation of Benefits (EOB)

a. Attach a copy of the EOB from your insurance company. This document should show how much you are responsible for paying for Dysport.

3 Include an Invoice From Your Provider

The invoice must include:

i. Name and address of the specialty pharmacy
ii. Patient name and IPSEN CARES Member ID
iii. Date of service
iv. Dysport or Healthcare Common Procedure Coding System (HCPCS) code
v. Amount billed for Dysport

OR

Include an Invoice From Your Specialty Pharmacy

The invoice must include:

i. Name and address of the specialty pharmacy
ii. Patient name and IPSEN CARES Member ID
iii. Date of service
iv. Dysport or Healthcare Common Procedure Coding System (HCPCS) code
v. Amount billed for Dysport

4 Submit Your Documents AND Upload Claims

a. You can send everything by:
   i. Fax: 1-833-671-1087
   OR
   ii. Mail:
   IPSEN CARES Copay Assistance Program
   2250 Perimeter Park Dr, Suite 300
   Morrisville, NC 27560

If you need assistance or have any questions, please contact IPSEN CARES at 1-866-435-5677, Monday through Friday, between 8:00 AM and 8:00 PM ET.

*Please see Terms and Conditions on the last page.

Please see full Prescribing Information for Dysport, including BOXED WARNING.

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Please complete and submit the form below

Section A: Patient Information			
First Name	Last Name		
Date of Birth (MM/DD/YYYY)			
Home Address			
Home Address 2	City	State	Zip

Section B: Provider Information			
First Name	Last Name		
Address			
Address 2	City	State	Zip

Section C: Claim Information		
Primary Insurance Co.		Insurance Co. Phone #
Subscriber Policy ID #	Policy/Employer/Group #	
Member ID	Date of Service (MM/DD/YYYY)	Provider Billed Amount

☐ I attest that I've received Dysport (NDC Numbers: 15054-0500-1, or 15054-0530-6)

Section D: Patient Signature

I certify that, to the best of my knowledge, the information on this reimbursement form is true and correct. By submitting this request, I certify that I have read the Terms and Conditions of the IPSEN CARES® Copay Assistance Program and that I am eligible to receive copay assistance from the Program on the claim I am submitting for reimbursement. I certify that I do not have Government Program insurance, as that term is defined in the Terms and Conditions of the IPSEN CARES Copay Assistance Program, and that I have paid my treatment provider or Specialty Pharmacy for my share of the cost of Dysport as determined by my private health insurance company. I understand that I am responsible for reporting receipt of the IPSEN CARES Copay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Copay Assistance Program, as may be required. I authorize the release of any medical information to third parties working on behalf of Ipsen necessary to process this request for copay assistance.

Signature	
Printed Name	Date (MM/DD/YYYY)

If you need assistance or have any questions, please contact IPSEN CARES at 1-866-435-5677, Monday through Friday, between 8:00 AM and 8:00 PM ET.

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Terms & Conditions

IPSEN CARES COPAY ASSISTANCE TERMS & CONDITIONS:

Patients are not eligible for copay assistance through IPSEN CARES® if they are enrolled in any state or federally funded programs for which drug prescriptions or coverage could be paid in part or in full, including, but not limited to, Medicare Part B, Medicare Part D, Medicaid, Medigap, VA, DoD, or TRICARE (collectively, "Government Programs"), or where prohibited by law. Patients must be United States residents (including its territories) and enrolled in IPSEN CARES® to receive copay program benefits. Patients residing in Massachusetts or Rhode Island can only receive assistance with the cost of Ipsen products but not the cost of related medical services (injection). Patients receiving assistance through another assistance program or foundation, free trial, or other similar offer or program, are not eligible for the copay assistance program during the current enrollment year.

An annual calendar year maximum copay benefit applies. Patients may remain enrolled in copay assistance as long as eligibility criteria is met.

Patients or guardians are responsible for reporting receipt of copay savings benefit to any insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled through the program, as may be required. Additionally, patients or guardians may not submit any benefit provided by this program for reimbursement through a Flexible Spending Account, Health Savings Account, Health Reimbursement Account, or otherwise to a government or private payor. Ipsen reserves the right to rescind, revoke, or amend these offers without notice at any time. Ipsen and/or its copay assistance vendor are not responsible for any transactions processed under this program where Medicaid, Medicare, or Medigap payment in part or full has been applied. Claim reimbursement requests must be submitted within 180 days of treatment date. Data related to patient participation may be collected, analyzed, and shared with Ipsen for market research and other purposes related to assessing the program. Data shared with Ipsen will be de-identified, meaning it will not identify the patient. Void outside of the United States and its territories or where prohibited by law, taxed, or restricted. This program is not health insurance. No other purchase is necessary. Copay assistance cannot be sold, purchased, traded, or counterfeited. Void if reproduced.

We are collecting personal information in order to fulfill your request. Please see Ipsen's Privacy Policy at https://www.ipsen.com/us/privacy-policy/. Residents of certain states have additional rights regarding the collection, use, and disclosure of their personal information. For more information, please see Ipsen's Supplemental State Privacy Notice at https://www.ipsen.com/us/Supplement-Website-Privacy-Notice/.

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