

IPSEN CARES®

Coverage, Access, Reimbursement & Education Support

The IPSEN CARES® Copay Assistance Program - Patient Reimbursement Form (Pharmacy Claims) may only be completed by the patient or the patient's authorized representative. This Form may be submitted, along with all required documentation, for the patient to receive reimbursement from the IPSEN CARES Copay Assistance Program for amounts the patient owes towards the cost of their Ipsen medication, consistent with the Terms and Conditions* of the IPSEN CARES Copay Assistance Program, including patient eligibility requirements. The patient is responsible for any amounts not covered by the Copay Assistance Program.

If the patient has any questions about submitting this claim or their participation in the Ipsen CARES Copay Assistance Program, the patient or his/her authorized representative should call IPSEN CARES Support at (866) 435-5677.

Submission Instructions:

1. Print out and complete this form entirely, and mail it with the following items:

Failure to include any of the following will result in claim rejection.

- The original pharmacy receipt/invoice received from your pharmacy which must include the following information:
 - ✓ Patient name and address
 - ✓ Pharmacy name, address, and phone number
 - ✓ Doctor or health care provider name, address, and phone number
 - ✓ Prescription Number (RX #), fill date, drug name, strength, NDC #, and quantity
 - ✓ Overall prescription price and copay amount/ out of pocket expense paid

2. Mail this form and the required documents to the address below:

IPSEN CARES®
2250 Perimeter Park Drive, Suite 300
Morrisville, North Carolina 27560

3. If eligible, you will receive a check for reimbursement in approximately 10-14 days.

Patient Information Fields:

First Name

Last Name

Address Line 1

Address Line 2

City

State

Zip Code

Phone

Email

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 my IPSEN Medication 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.

Print Name

Signature

Date

***Copay Assistance Program Patient Eligibility & Terms and 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.

