IPSENCARES®
Coverage, Access, Reimbursement & Education Support

onivyde®
(irinotecan liposome injection)

QUESTIONS? CALL IPSEN CARES AT 1-866-435-5677

HOW TO ENROLL IN THE IPSEN CARES PATIENT SUPPORT PROGRAM

IPSEN CARES serves as a central point of contact between patients/caregivers, healthcare providers, insurance companies, and specialty pharmacies.

Instructions for Patients

- You need to complete **Steps 1, 2, 3, 4,*** and read **Step 8** outlined in **dark blue** on the Enrollment Form.
- Your healthcare provider will complete the steps outlined in **green**.
- It's important to fill out all sections completely to prevent enrollment delays.

☐ Fill out the **Patient Information** section in **Step 1**.

☐ Fill out the **Insurance Information** section in **Step 2**.

☐ Fill out the **IPSEN CARES Copay Program** section in **Step 3** if requesting copay assistance.

☐ Fill out the **Patient Assistance Program (PAP)** section in **Step 4** if requesting PAP.

☐ Sign the **PATIENT AUTHORIZATION AND ADDITIONAL PRODUCT AND SUPPORT INFORMATION** box under **Step 3** after you read the information in **Step 8**.

Your healthcare provider will complete the remainder of the form and fax the appropriate pages to IPSEN CARES.

Instructions for Prescribers

☐ Fill out the **Prescriber Information** sections in **Steps 5-7.**

☐ Sign and date the **PRESCRIBER ATTESTATION** at the end of **Step 7**.

☐ Fax the completed form to 1-888-525-2416. IPSEN CARES must receive pages 2-7 in order for the Enrollment Form to be complete. Note, Page 3 can be left blank if the patient is not seeking to participate in the Patient Assistance Program.

Once a completed Enrollment Form is received, an IPSEN CARES Patient Access Manager will perform a benefits verification and review the patient's coverage and out-of-pocket responsibility with both the prescriber and the patient, typically within 1 business day. To learn more about IPSEN CARES and support offerings, please call 1-866-435-5677, Monday – Friday, 8:00 AM – 8:00 PM ET or visit IPSENCARES.com.

*Required for patients seeking to participate in the Patient Assistance Program.

Please see accompanying full Prescribing Information, including BOXED WARNING.

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Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416

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Completed by the patient/legal guardian

STEP 1

PATIENT INFORMATION

Patient Name (First & Last) _____ Home Phone # _____

Address _____ Cell Phone # _____

City _____ Caregiver/Legal Guardian Name (First & Last)

State _____ Zip _____ _____

Date of Birth (MM/DD/YY) ____ / ____ / ____ Caregiver/Legal Guardian Phone # _____

Sex ☐ Male ☐ Female ☐ Other/Undisclosed Relationship to Patient _____

Email _____ Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening

Would you like to receive text messages from Ipsen for the purposes of helping you participate in IPSEN CARES patient support programs and/or stay on therapy, as described in Step 8 on Page 7, under *Additional Product and Support Information*? I give permission to Ipsen to contact me by text message for the purposes described in Step 8 on Page 7. Carrier, text, and data rates may apply. ☐ Yes ☐ No

Would you like to receive marketing information from Ipsen as described in Step 8 on Page 7 under *Additional Product and Support Information*? I give permission to Ipsen to contact me with information via mail, email, phone, or text message, all of which may include marketing, advertisements, disease state awareness materials, and educational material about Onivyde and programs that support patients. I understand and agree that any information I provide may be used by Ipsen to conduct data analysis and market research, and to develop new programs and resources. Automatic dialing may be used. Carrier, text, and data rates may apply. I understand that I am not required to provide this consent as a condition of purchasing any goods or services. ☐ Yes ☐ No

STEP 2

INSURANCE INFORMATION

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

Primary Insurance Co. _____ Secondary Insurance Co. _____

Insurance Co. Phone # _____ Insurance Co. Phone # _____

Subscriber Policy ID # _____ Subscriber Policy ID # _____

Policy/Employer/Group # _____ Policy/Employer/Group # _____

Is Physician a Participating Provider? ☐ Participating ☐ Non-Participating

STEP 3

IPSEN CARES COPAY PROGRAM (Required for patients seeking to participate in the Onivyde Copay Assistance Program)

Eligible patients using commercial insurance can save on out-of-pocket Ipsen medication costs. Please see Patient Eligibility & Terms and Conditions.

I attest that I am not enrolled in any health insurance plan from any state or federally funded programs (including, but not limited to, Medicare or Medicaid, VA, DOD, or TRICARE) and agree to the Terms and Conditions of the Copay Program. ☐ Yes ☐ No

☐ I would like IPSEN CARES to check my eligibility for, and enroll me into, the Onivyde Copay Assistance Program if the results of this benefit verification determine that I have commercial or private health insurance.

PATIENT AUTHORIZATION AND ADDITIONAL PRODUCT AND SUPPORT INFORMATION

I have read and understand the IPSEN CARES Patient Authorization on Page 6 (Step 8) and agree to the terms. To the extent marked Yes above in Step 1, I have read and understand the Additional Product and Support Information on Page 7 (Step 8) and agree to the terms.

Patient/Legal Guardian Signature _____ **Date** _____

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Completed by the patient/legal guardian

IPSEN CARES PATIENT ASSISTANCE PROGRAM APPLICATION

(Required for patients seeking to participate in the Patient Assistance Program)

The Patient Assistance Program (PAP) is designed to provide Onivyde at no cost to eligible patients. Patients may be eligible to receive free drug if they are experiencing financial hardship and meet financial eligibility criteria, are uninsured or functionally uninsured, are residents of the U.S., and received a valid prescription for an on-label use of Onivyde as supported by information provided in the program application. Eligibility does not guarantee approval for participation in the program. Free Onivyde provided by the PAP is intended only for the patient named in the application and must not be sold, transferred, or otherwise diverted. Patients must not seek reimbursement for the free drug provided by the PAP. The PAP provides Onivyde product only, and does not cover the cost of previously purchased product or medical services. The PAP is not insurance. By submitting an application for the PAP, patient agrees to abide by these program terms.

STEP 4

PROOF OF INCOME*

My estimated annual household income currently is $ _____ Number of people in household _____

***IPSEN CARES will conduct a soft credit check as part of the process of confirming income and determining eligibility for the program.**

THIRD PARTY VERIFICATION AUTHORIZATION

I understand that I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing the IPSEN CARES Patient Assistance Program (the "Program"), Ipsen Biopharmaceuticals, Inc. ("Ipsen"), and its vendor, on an ongoing basis as needed for the duration of my participation in Program, under the FCRA, to obtain information from my credit profile or other information from a credit reporting agency (including, without limitation, Experian Health), for the purpose of determining financial qualifications and eligibility for programs administered by Ipsen and the Program. I understand that I am affirmatively agreeing to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare or any public or private assistance program or any other form of insurance. If my income or health coverage changes, I will call the Program at 1-866-435-5677.

Patient/Legal Guardian Signature _____ **Date** _____

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Completed by the prescriber

STEP 5

PRESCRIBER INFORMATION

Prescriber Name (First & Last) _____

State License # _____

Tax ID # _____ NPI # _____

Medicaid Provider # (Required if Medicaid Patient) _____

Provider Transaction Access # (PTAN) _____

Office/Institution _____

Specialty _____

Street Address _____

City _____ State _____ Zip _____

Office Contact and Title _____

Phone # _____ Fax # _____

Email _____

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening

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Completed by the prescriber

STEP 6

DIAGNOSIS

Primary ICD-10 Code _____ Secondary ICD-10 Code (optional) _____

STEP 7

PRESCRIPTION AND PRESCRIBER ATTESTATION

Complete this section if you would like IPSEN CARES to triage the prescription to a specialty pharmacy or if the patient is seeking enrollment in the PAP.

PRESCRIPTION: Onivyde® (irinotecan liposome injection)

Patient Name (First & Last) _____ Date of Birth (MM/DD/YY) ____ / ____ / ____

Sex ☐ Male ☐ Female ☐ Other/Undisclosed

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

Onivyde Strength	Route of Administration	Frequency	Directions	Quantity	Refills
	Intravenous injection				

PRESCRIBER ATTESTATION

(The Prescriber must sign if this form is to be used as a prescription to be triaged to a specialty pharmacy to enroll the patient for free goods as part of the Patient Assistance Program (PAP), or to enroll a patient for free goods as part of the Temporary Patient Assistance Program (TPAP). If the request is limited to Benefit Verification or Copay Assistance Program support, the Prescriber, or an individual acting at the direction of the Prescriber and involved in the patient's care, such as an Office Practice Manager, Financial Coordinator, Financial Counselor, Patient Assistance Coordinator, Patient Navigator, Social Worker, Insurance Coordinator, Patient Coordinator, or Patient Care Advocate, may sign this form.)

By signing below, I certify that the therapy referenced in this form is medically necessary. If this form is to be used to enroll a patient in free goods as part of the PAP or Temporary PAP, I certify that the therapy referenced in this form is prescribed consistent with an FDA-approved indication. I certify that a prescription signed by a licensed prescriber is on file for the referenced therapy and that I have received the necessary authorization from the patient and/or the patient's guardian to release the information herein 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 and its agents or contractors to forward a prescription by fax or other delivery mode to the designated pharmacy. I understand that I must comply with applicable state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me. I certify that any medications received by me or on my behalf 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, transfer, or otherwise diverted. Additionally, no claim for reimbursement will be submitted concerning these medications, or any services provided by IPSEN CARES, 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.

Name (First & Last) _____ **Title** _____

Prescriber Signature _____ **Date** _____

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Completed by the patient/legal guardian

STEP 8

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: IPSEN CARES® PROGRAM

I authorize my doctor(s) and their staff (including those pharmacies that may receive my prescription for Onivyde) to disclose my protected health information ("PHI"), including health information about insurance, prescription, care management, and medical condition to Ipsen Biopharmaceuticals, Inc., and/or its affiliates, and/or its agents or third party vendors that have been hired to administer the Ipsen Coverage, Access, Reimbursement & Education Support (IPSEN CARES) program (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 doctors 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 provider; and (6) facilitate my participation in Onivyde patient programs as I have requested or may request, including the IPSEN CARES Patient Assistance Program (the "PAP") if applicable. I agree that, using the contact information I provide, Ipsen may contact me by phone, mail, and/or email for reasons related to the IPSEN CARES program and support services, including (1) determining if I am eligible for assistance and related support services, (2) leaving messages for me that disclose that I am on Onivyde therapy and/or applied for IPSEN CARES support services and am or am not eligible for assistance; (3) operating Ipsen Cares patient programs that might help me pay for or access my medicines; and (4) confirming receipt of medications. 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 also give Ipsen permission to share my PHI and other information with people and companies that work with IPSEN CARES, including insurance providers; my doctor(s) and other people, or institutions who are involved in my healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for my medication. All information that I provide may be used by Ipsen or any third party working on behalf of Ipsen in connection with IPSEN CARES. I understand that my healthcare providers may receive remuneration from Ipsen in connection with my PHI and/or for any therapy support services provided to me.

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 make reasonable efforts to protect my 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, 2250 Perimeter Park Dr. Suite 300 Morrisville, NC 27560, 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, I will not be able to participate in IPSEN CARES, 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 three years from the date signed unless a shorter time is required by law or unless I revoke my authorization before that time. I understand that I will receive a copy of the signed authorization.

I confirm that any information, including financial and insurance information, that I provide to IPSEN CARES 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 immediately notify IPSEN CARES at 1-866-435-5677. I confirm that I am a resident of the United States (including its territories). I understand that Ipsen may revise, change, or terminate this program at any time without notice.

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Completed by the patient/legal guardian

STEP 8 (continued)

ADDITIONAL PRODUCT AND SUPPORT INFORMATION

Text Communications

To the extent that I have opted in under Step 1 of this form, I agree to be contacted by autodialed text messages ("texts") at the mobile phone number I have provided for the purpose of helping me stay on therapy, which may promote or advertise the Ipsen products included in the therapy plan, and/or which may include provision of educational materials and information about programs that support patients. 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 or all text communications entirely at any time by calling 1-866-435-5677 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. This authorization expires three years from the date signed unless a shorter time is required by law or unless I revoke my authorization before that time. 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.

Marketing Information

To the extent that I have opted in under Step 1 of this form, I would like to receive information from Ipsen via mail, email, phone or text message, all of which may include marketing content, advertisements, disease state awareness materials 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. I agree that Ipsen and its agents may use and disclose my personal information (including name, address, phone number, and/or email) to provide this information and Ipsen may also contact me to solicit my opinions regarding Onivyde and Ipsen's products and services. I understand and agree that any information I provide may be used by Ipsen to conduct data analysis and market research, and to develop new programs and resources. I understand that my cell phone carrier's standard rates may apply for calls and texts to my cell phone. This authorization expires three years from the date signed unless a shorter time is required by law or unless I revoke my authorization before that time. I may revoke this authorization, by calling 1-866-435-5677 or sending a request in writing to: IPSEN CARES, 2250 Perimeter Park Dr. Suite 300 Morrisville, NC 27560. 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.

Please see accompanying full Prescribing Information, including BOXED WARNING.

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/.

IPSENCARES® Coverage, Access, Reimbursement & Education Support