IPSEN CARES®
Coverage, Access, Reimbursement & Education Support

Somatuline® Depot
(lanreotide) Injection 60 mg 90 mg 120 mg

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

HOW TO ENROLL IN 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

- Your Healthcare Provider will complete the Steps Outlined in **Green**.
- You need to complete **Steps 1, 2, 3, and 8** Outlined in **Blue** on the Enrollment Form.
- Fill out all sections completely. Missing information could delay your enrollment in IPSEN CARES.
  - ☐ 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**.
  - ☐ Sign the **PATIENT AUTHORIZATION AND ADDITIONAL PRODUCT AND SUPPORT INFORMATION** box under **Step 3** after you read the information in **Step 8**.

Your provider will complete the remainder of the form and fax pages 2, 3, 4, & 5 to IPSEN CARES.

Instructions for Prescribers

- ☐ Fill out the **Prescriber Information Sections** in **Steps 4-7.**
- ☐ Sign and date the **PRESCRIBER/OFFICE MANAGER ATTESTATION** at the end of **Step 7B**.
- ☐ Fax the completed form to **1-888-525-2416**. IPSEN CARES must receive pages 2, 3, 4, & 5 in order for the Enrollment Form to be complete.

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

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Completed by the patient/legal guardian

STEP 1

PATIENT INFORMATION

Patient Name (First & Last) _____

Patient Address _____

City _____

State _____ Zip _____

Date of Birth (MM/DD/YY) ____ / ____ / ____

Email _____

Home Phone # _____

Mobile Phone # _____

Caregiver/Legal Guardian Name (First & Last)

_____

Caregiver/Legal Guardian Phone # _____

Relationship to Patient _____

Would you like to enroll in the Ipsen adherence text messaging program as outlined on Page 6, in Step 8 under *Additional Product and Support Information*? I give permission to Ipsen to contact me by SMS/text message for the Ipsen adherence text messaging program. Carrier, text, and data rates may apply. ☐ Yes ☐ No

Would you like to receive marketing information from Ipsen as described on Page 6, in Step 8 under *Additional Product and Support Information*? I give permission to Ipsen to contact me with information via mail, email, phone, or SMS/text message, all of which may include marketing, advertisements, disease state awareness materials and educational material about Somatuline Depot and programs that support patients. 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

Primary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

Does patient have secondary insurance? ☐ Yes ☐ No

Secondary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

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

STEP 3

IPSEN CARES COPAY 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 Somatuline Depot Copay 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 and Additional Product and Support Information on Pages 5 and 6, in Step 8 and agree to the terms.

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

Somatuline® Depot (lanreotide) Injection 60 mg 90 mg 120 mg

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Completed by the prescriber

STEP 4

PRESCRIBER INFORMATION

Prescriber Name (First & Last) _____

State License # _____

Tax ID # _____ NPI # _____

Medicaid Provider # (Required if Medicaid Patient) _____

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

PATIENT SUPPORT

Would you like to request Nurse Home Health Administration of Somatuline Depot for your patient by an IPSEN CARES nurse if the patient is eligible? ☐ Yes ☐ No

Would you like to request HCP injection training from an IPSEN CARES nurse for your staff? ☐ Yes ☐ No

If yes, requested location for training is ☐ Prescriber's Office ☐ Other MD Office/Clinic (Please Specify) _____

STEP 5

SPECIALTY PHARMACY OR BUY & BILL

Are you going to utilize Specialty Pharmacy or Buy & Bill? ☐ Specialty Pharmacy ☐ Buy & Bill

Complete the following if you are going to use a Specialty Pharmacy.

If you would like IPSEN CARES to triage the prescription to a Specialty Pharmacy, complete the Prescription information in Step 7A.

Preferred Specialty Pharmacy _____

Was Rx sent to a Specialty Pharmacy already? ☐ Yes ☐ No

If yes, please provide the name of the Specialty Pharmacy _____

STEP 6

DIAGNOSIS

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

STEP 7A

PRESCRIPTION AND PRESCRIBER/OFFICE MANAGER ATTESTATION

(Complete this section if you would like IPSEN CARES to triage the prescription to a Specialty Pharmacy.)

PRESCRIPTION Somatuline® Depot (lanreotide) injection

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

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

Please fill in the requested information in the table below.

Somatuline Depot Strength	Route of Administration	Frequency	Directions	Quantity	Refills
	Deep subcutaneous injection				

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Completed by the prescriber

STEP 7B

PRESCRIBER/OFFICE MANAGER ATTESTATION

(The Prescriber must sign if this form is to be used as a prescription to be triaged to a Specialty Pharmacy, to request Injection Training, to request Nurse Home Health Administration (NHHA), to enroll a 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 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 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 information herein and medical and/or patient information relating to Somatuline® Depot therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for Somatuline® Depot therapy, assisting in initiating or continuing Somatuline® Depot 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 any medications received from Ipsen, 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 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 _____

Signature _____ Date _____

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 8

PATIENT AUTHORIZATION AND SIGNATURE – IPSEN CARES® PROGRAM

I authorize my healthcare providers (including those pharmacies that may receive my prescription for Somatuline® Depot), 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 Somatuline® Depot; (3) communicate with my healthcare providers and health plans about my treatment plan; (4) provide support services including patient education and financial assistance for Somatuline® Depot; (5) help get Somatuline® Depot 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 Somatuline® Depot 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 Somatuline® Depot 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 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.

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 8 (continued)

ADDITIONAL PRODUCT AND SUPPORT INFORMATION

Text Adherence Program

To the extent that I have opted in under step one of this form, 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 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 one of this form, I would like to receive information from Ipsen via mail, email, phone or SMS/text message, all of which may include marketing content, advertisements, disease state awareness materials and educational material about SOMATULINE® DEPOT, 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 SOMATULINE® DEPOT 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 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 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.

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/.

Please see accompanying full **Prescribing Information** and **Patient Information**.