

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



The Patient Assistance Program (PAP) is designed to provide Somatuline Depot at no cost to eligible patients. Patients may be eligible to receive free drug if they are experiencing financial hardship, are uninsured or functionally uninsured, are US residents, and received a valid prescription for an on-label use of Somatuline Depot as supported by information provided in the program application. Eligibility does not guarantee approval for participation in the program. The PAP provides Somatuline Depot product only, and does not cover the cost of previously purchased product or medical services.

Completed by the patient/legal guardian

**STEP 1**

**PATIENT INFORMATION**

Patient Name (First & Last) \_\_\_\_\_ Home Phone # \_\_\_\_\_  
 Patient Address \_\_\_\_\_ Mobile Phone # \_\_\_\_\_  
 City \_\_\_\_\_ Caregiver/Legal Guardian Name (First & Last) \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Caregiver/Legal Guardian Phone # \_\_\_\_\_  
 Email \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**INSURANCE INFORMATION**

Complete the information below or fax a copy of the front and back of patient’s primary and secondary insurance cards for pharmacy and medical benefits.

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 (check one)  Participating  Non-Participating  
 **Uninsured** - Patient does not have commercial health insurance and is not eligible for public health insurance, including but not limited to Medicare or Medicaid, or has been denied coverage by their health insurance.

**STEP 2**

**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.

**STEP 3**

**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 Fair Credit Reporting Act (“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.

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STEP 3 (continued)

**THIRD PARTY VERIFICATION AUTHORIZATION (continued)**

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** \_\_\_\_\_

Completed by the patient/legal guardian

STEP 4

**PATIENT AUTHORIZATION**

I authorize my/the patient's healthcare providers and their staff (including those pharmacies that may receive my/the patient's prescription for Somatuline<sup>®</sup> Depot) to disclose personal health information ("PHI") about me/the patient, including health information relating to my/the patient's 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<sup>®</sup>) program on its behalf (collectively "Ipsen") in order for Ipsen to: (1) enroll me/the patient in the IPSEN CARES<sup>®</sup> Patient Assistance Program (the "PAP") if I/the patient am/is eligible; (2) establish my/the patient's benefit eligibility for assistance related to potential out-of-pocket costs for Somatuline<sup>®</sup> Depot; (3) send me information about the PAP and other programs that might help me/the patient pay for my/the patient's medicines; (4) help get Somatuline<sup>®</sup> Depot shipped to my/the patient's healthcare provider; and (5) facilitate my/the patient's participation in Somatuline<sup>®</sup> Depot patient programs as I have requested or may request.

I agree that, using the contact information I provide, Ipsen may contact me for reasons related to the IPSEN CARES<sup>®</sup> PAP to (1) determine if I/the patient am/is eligible for assistance and related support services; (2) leave messages for me that may disclose that I/the patient am/is or am not/is not eligible for assistance; (3) operate the PAP and other programs that might help me pay for my/the patient's medicines; (4) send my/the patient's information to other programs that might help me pay for my/the patient's medicines; (5) ask me for financial, insurance, and/or medical information; and/or (6) share my/the patient's information as required or permitted by law. I authorize the PAP to use information on this application and any other information I give to the PAP for these same reasons. I also give Ipsen permission to share my/the patient's PHI and other information with people and companies that work with the PAP; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my/the patient's doctor(s) and other people, or institutions who are involved in my/the patient's healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for my/the patient's medication. All information that I provide may be used by Ipsen, or any third party working on behalf of Ipsen, in connection with the PAP. I also consent to being contacted by an IPSEN CARES<sup>®</sup> program representative to obtain further information or clarification regarding any adverse event I/the patient may experience.

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Completed by the patient/legal guardian

**STEP 4 (continued)**

**PATIENT AUTHORIZATION (continued)**

I understand that once my/the patient’s PHI has been disclosed to Ipsen, privacy laws may no longer restrict its use or disclosure. However, Ipsen agrees to protect my/the patient’s information by using and disclosing it only for the purposes described above or as required. I understand that my/the patient’s healthcare providers may receive remuneration from Ipsen in exchange for my/the patient’s PHI and/or for any therapy support services provided to me/the patient.

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 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 my authorization. I understand that I may refuse to sign this form and, if I do so, I/the patient will not be able to participate in the PAP, but it will not affect my/the patient’s eligibility to obtain medical treatment, my/the patient’s ability to seek payment for this treatment, or affect my/the patient’s 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 promise that any information, including financial and insurance information, that I provide to the PAP 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 coverage changes, I will notify IPSEN CARES® at 1-866-435-5677. I understand that Ipsen has the right to contact me directly to confirm receipt of medications. Ipsen may revise, change, or terminate this program at any time.

**Patient/Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

We are collecting personal information in order to fulfill your request. Please see Ipsen’s privacy policy at <https://www.ipсен.com/us/privacy-policy/>.

Completed by the prescriber

**STEP 5**

**PRESCRIBER INFORMATION**

Prescriber Name (First & Last) _____	Street Address _____
State License # _____	City _____ State _____ Zip _____
Tax ID # _____ NPI # _____	Office Contact and Title _____
Medicaid Provider # (Required if Medicaid Patient) _____	Phone # _____ Fax # _____
Office/Institution _____	Email _____
Specialty _____	Preferred Method of Contact    Phone    Fax    Email
	Best Time to Contact    Morning    Afternoon    Evening

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STEP 6

**DIAGNOSIS**

Primary ICD-10 Code \_\_\_\_\_ Secondary ICD-10 Code (optional) \_\_\_\_\_

STEP 7A

**PRESCRIPTION AND PRESCRIBER ATTESTATION**

**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				

STEP 7B

**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 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).]

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 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 provided by 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.

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Completed by the prescriber