Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416.
IPSEN CARES must receive pages 1 and 2 in order for the form to be complete.

PLEASE BE SURE TO REVIEW ORIGINAL IPSEN CARES ENROLLMENT FORM

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

I authorize my/the patient's healthcare providers (including those pharmacies that may receive my/the patient's prescription for Tazverik) 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) program on its behalf (collectively "Ipsen") in order for Ipsen to: (1) enroll me/the patient in IPSEN CARES Patient Assistance Program ("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 Tazverik; 3) send me information about the PAP and other programs that might help me/the patient pay for my/the patient's Tazverik; (4) provide support services, including patient education and financial assistance for Tazverik; (5) help get Tazverik shipped to my/the patient's healthcare provider; and (6) facilitate my/the patient's participation in Tazverik 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 program and support services and may leave messages for me that may disclose that I/the patient am/is on Tazverik 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/the patient may experience.

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 by law. 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, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, 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/the patient will not be able to participate in IPSEN CARES programs, 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.

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PLEASE BE SURE TO REVIEW ORIGINAL IPSEN CARES ENROLLMENT FORM

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

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 the product, which includes Medicare, Medicaid, 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 Name (First & Last) ____________________

Patient Date of Birth (mm/dd/yy) ____ / ____ / ____

Home Phone # ____________________

Mobile Phone # ____________________

Caregiver/Legal Guardian Name (First & Last) ____________________

Caregiver/Legal Guardian Phone # ____________________

Relationship to Patient ____________________

Signature of Patient/Legal Guardian ____________________ Date ____________________

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