

Please print the form, fill it out completely, sign it, and fax to: 1-855-465-3820

The Patient Assistance Program (PAP) is designed to provide Ipsen medication 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, residents of the U.S., and received a valid prescription for an on-label use of Ipsen medication as supported by information provided in the program application. Eligibility does not guarantee approval for participation in the program. Free Ipsen medication 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 the prescribed Ipsen medication 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.

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 confirm that any information, including financial and insurance information, that I provide to IPSEN CARES is complete and true, and I will immediately notify IPSEN CARES in the event my health insurance coverage changes. I also understand that Ipsen may revise, change, or terminate this program at any time without notice. If my income or health coverage changes, I will call the Program at 1-866-435-5677.

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