Dysport® (abobotulinumtoxinA)

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

IPSEN CARES must receive pages 1, 2, and 3 in order for the form to be complete.

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

Completed by the patient

STEP 1

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____/_____/_____ Gender ☐ Male ☐ Female

Mailing Address _____ Apt # _____

City _____ State _____ Zip _____

Phone # _____ Are you a US resident? ☐ Yes ☐ No

Email Address _____

Prescribing Physician _____ Treating Facility _____

INSURANCE INFORMATION

Complete or attach front and back copy of patient's primary and secondary insurance cards for pharmacy and medical benefits.

Primary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

Secondary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

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 _____

* Examples of income can include, but not limited, to Social Security Disability Income, Supplemental Security Income, Aid from the Department of Public Welfare, Unemployment Benefits, Workers Compensation Benefits, Dividends, interest or investment account, Employment (myself and or my spouse), Other (includes assistance from friends, family, charity or church)

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STEP 3

Completed by the patient

PATIENT AUTHORIZATION

I authorize my/the patient's doctor(s) and their staff to disclose my/the patient's personal health information ("PHI"), including information about my/the patient's insurance, prescription, and medical condition to Ipsen Biopharmaceuticals, Inc., and/or its agents or third party vendors (collectively, "Ipsen") and the Dysport® Patient Assistance Program (the "PAP"). I know that the information I provide will be used by the PAP to: (1) decide if I/the patient am/is eligible for assistance; (2) operate the PAP; (3) send me information about 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 understand that once my/the patient's 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/the patient's 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®, 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 this 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 one year after the date I sign it below. 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.ipsen.com/us/privacy-policy/.

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Completed by the prescriber

STEP 4

HEALTHCARE PROVIDER INFORMATION

Prescriber Name _____ Street Address _____

DEA # _____ State License _____

Tax ID # _____ NPI # _____ City _____ State _____ Zip _____

Medicaid Provider # _____ Office Contact and Title _____

Medicare PTAN # _____ Phone # _____ Fax # _____

Office/Institution _____ Email Address _____

Specialty _____ Preferred Method of Contact ☐ Phone ☐ Fax

STEP 5

PRESCRIBER ATTESTATION

The Prescriber must sign this form to enroll the patient for free goods as part of the Patient Assistance Program (PAP).

By signing below, I certify that the therapy referenced in this form is medically necessary and that I have received the necessary authorization to release the information herein and medical and/or patient information relating to Dysport® 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 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 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.

Prescriber Signature _____ **Date** _____

IPSEN CARES® Patient Assistance Program Application
Questions? Call IPSEN CARES® at 1-866-435-5677

IPSEN CARES® Coverage, Access, Reimbursement & Education Support