# IPSEN CARES® PATIENT AUTHORIZATION FORM

Questions? Call IPSEN CARES at 1-866-435-5677

increlex® (mecasermin) injection 10 mg

**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 IPSEN CARES® PROGRAM

I authorize my/the patient's healthcare providers (including those pharmacies that may receive my/the patient's prescription for INCRELEX®) 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®; (2) establish my/the patient's benefit eligibility and potential out-of-pocket costs for INCRELEX®; (3) communicate with my/the patient's healthcare providers and health plans about my/the patient's treatment plan; (4) provide support services, including patient education and financial assistance for INCRELEX®; (5) help get INCRELEX® shipped to me/the patient; and (6) facilitate my/the patient's participation in INCRELEX® 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 am/the patient is on INCRELEX® 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, 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 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.

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/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.

Patient Name (First & Last) _____

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

Parent/Legal Guardian Phone # _____

Parent/Legal Guardian Name (First & Last Name) _____

Relationship to Patient _____

Signature of Parent/Legal Guardian _____ Date _____

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## ADDITIONAL PRODUCT AND SUPPORT INFORMATION

### TEXT ADHERENCE PROGRAM

☐ I agree to be contacted by autodialed text messages ("texts") at the mobile phone number I have provided below for the purpose of helping 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 other 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

☐ I would like to receive information from Ipsen via mail, email, phone or SMS/text, all of which may include telemarketing, advertisements, disease state awareness materials and educational material about INCRELEX® 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 INCRELEX® 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.

Patient Name (First & Last) _____

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

Parent/Legal Guardian Phone # _____

Parent/Legal Guardian Name (First & Last Name) _____

Relationship to Patient _____

Signature of Parent/Legal Guardian _____ 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/.



IPSEN CARES Coverage, Access, Reimbursement & Education Support