



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 INCRELEX® (mecasermin) injection 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 INCRELEX, as supported by information provided in the Program application. Eligibility does not guarantee approval for participation in the program. The PAP provides INCRELEX 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. \_\_\_\_\_ 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 \_\_\_\_\_

\* 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

**PATIENT AUTHORIZATION**

As parent and/or guardian of the patient, I authorize the patient’s doctor(s) and their staff to disclose the patient’s personal health information (“PHI”), including information about insurance, prescription, and medical condition to Ipsen Biopharmaceuticals, Inc. and/or its agents or third-party vendors (collectively, “Ipsen”) and the Increlex® Patient Assistance Program (the “PAP”). I know that the information I provide will be used by the PAP to: (1) decide if the patient is eligible for assistance; (2) operate the PAP; (3) send me information about the PAP and other programs that might help me pay for the patient’s medicines; (4) send information to other programs that might help me pay for the patient’s medicines; (5) ask me for financial, insurance, and/or medical information; and/or (6) share my information and 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 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; the patient’s doctor(s) and other people, or institutions who are involved in the patient’s healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for 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 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 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, the patient will not be able to participate in the PAP, but it will not affect the patient’s eligibility to obtain medical treatment, the patient’s ability to seek payment for this treatment or affect 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 insurance 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 Biopharmaceuticals, Inc., may revise, change, or terminate this program at any time.

Parent/Legal Guardian Name \_\_\_\_\_ Parent/Legal Guardian Relationship \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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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 INCRELEX® 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