Somatuline® Depot
(lanreotide) Injection 60 mg 90 mg 120 mg

Please print the form, fill it out completely, sign it, and
FAX TO 1-888-525-2416

IPSEN CARES®
Nurse Home Health Administration Supplemental Form

(For use only after full IPSEN CARES Enrollment Form has been completed and submitted)

To be completed by physician.

PATIENT INFORMATION

Patient Name (First & Last) _____

Patient Address _____

City _____ State _____ Zip _____

Caregiver/Alternate Contact Name _____

Relationship of Caregiver/Alternate Contact to Patient _____

Caregiver/Alternate Contact Phone # (_____) _____

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

Email Address _____

Home Phone # (_____) _____ Other Phone # (_____) _____

Preferred Language _____

PRESCRIBER

Prescriber Name _____

DEA # _____ State License # _____

Tax ID # _____ NPI # _____

Medicaid Provider # (Required if Medicaid Patient) _____

Medicare PTAN # (Required if Medicare Patient) _____

Office/Institution _____

Specialty ☐ Oncologist ☐ Endocrinologist ☐ Other _____

Street Address _____

City _____ State _____ Zip _____

Office Contact and Title _____

Phone # (_____) _____ Fax # (_____) _____

Email Address _____

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

PRESCRIBER ATTESTATION

(The Prescriber must sign if this form is to be used as a request for Nurse Home Health Administration)

By signing below, I certify that I have previously completed a full prescribing form for the above named patient, and through this form intend to order Nurse Home Health Administration for the patient. A prescription signed by a me or another licensed prescriber is on file for the above therapy and that the patient named on this form has provided the necessary authorization to release the above referenced information and medical and/or patient information relating to Somatuline Depot therapy Nurse Home Health Administration to Ipsen and its agents or contractors for the purpose of in initiating Somatuline Depot therapy Nurse Home Health Administration.

I certify that any medications or Nurse Home Health Administration services received from Ipsen in connection with any IPSEN CARES program will be used only for the named patient.

Additionally, no claim for reimbursement will be submitted concerning these medications to any payor, including Medicare, Medicaid, or any other federal or state health insurance program, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in IPSEN CARES Nurse Home Health Administration exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

Prescriber/Office Manager Name _____ Title _____

Prescriber/Office Manager Signature _____ Date _____

IPSEN CARES®
Coverage. Access. Reimbursement & Education Support