IPSEN CARES® Healthcare Provider Enrollment Form

OVERVIEW

The IPSEN CARES individualized support program is a confidential and voluntary program. IPSEN CARES provides disease and treatment education and assists appropriate patients with gaining access to Ipsen product, as prescribed, throughout the patient's treatment journey.

IPSEN CARES®
Coverage, Access, Reimbursement & Education Support

Please note that some IPSEN CARES program offerings may only be available with the consent of the patient's healthcare provider and/or after a confirmed diagnosis or prescription.

HOW TO ENROLL IN THE IPSEN CARES PROGRAM

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

- Fill out the **Healthcare Provider** section in **STEPS 1-5** on pages 2-3.
- Fill out all sections completely. Please be sure that **all fields marked with an asterisk** are filled out, as that information is required.
- Sign and date the **PRESCRIBER ATTESTATION** section at the end of **STEP 5**.
- There are 2 options for returning this form:
  1. Scan and email the completed form to support@ipsencares.com, or
  2. Fax the completed form to 650-243-5193.

Please see full Prescribing Information, including Medication Guide with IMPORTANT WARNING.

Questions? Call IPSEN CARES at 844-484-1234.

TO BE COMPLETED BY THE HEALTHCARE PROVIDER

If you have questions, please call 844-484-1234, Monday – Friday, 8 am – 8 pm ET.

Completed by the Healthcare Provider

STEP 1 PATIENT INFORMATION

Patient Name (First & Last)* _____

E-mail _____

The form must include the following Caregiver Contact Information (required if patient is under 18 years of age)

Caregiver Name _____

Caregiver E-mail _____

Sex: ☐ Male ☐ Female ☐ Other/Undisclosed

Date of Birth (MM/DD/YY)* _____ /_____ /_____

Phone # (_____) _____ - _____

Relationship to Patient _____

Caregiver Phone # (_____) _____ - _____

STEP 2 PRESCRIBER INFORMATION

Prescriber Name* _____

DEA # _____ State License # _____

Tax ID #* _____ NPI #* _____

Medicaid Provider # _____

Medicare PTAN # (Required if Medicare Patient) _____

Office/Institution _____

Specialty _____

Office Contact and Title _____

Street Address* _____

City* _____

State* _____ Zip* _____

Phone #* (_____) _____ - _____

Fax #* (_____) _____ - _____

Email* _____

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening

STEP 3 DIAGNOSIS CODE

Primary ICD-10 Code* _____

Secondary ICD-10 Code _____

STEP 4 PRESCRIPTION AND DOSING INFORMATION

PRESCRIPTION SOHONOS™ (palovarotene)

Patient Name (First & Last) _____ Date of Birth (MM/DD/YY) _____ /_____ /_____

(Complete the information below if you would like IPSEN CARES to triage the prescription to a Specialty Pharmacy)

Strengths:

☐ 1 mg ☐ 1.5 mg ☐ 2.5 mg ☐ 5 mg ☐ 10 mg

Day Supply _____ # of Refills _____ Sig _____

Please select*

Prescriber's Signature _____ Date _____

☐ Dispense as Written

Prescriber's Signature _____ Date _____

☐ Substitution Permissible

Healthcare Provider Section continued on next page.

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Completed by the Healthcare Provider

STEP 5

PRESCRIBER ATTESTATION

The Prescriber must sign if this form is to be used as a prescription to be triaged to a Specialty Pharmacy, to enroll a patient for free goods as part of the Patient Assistance Program (PAP), to enroll a patient for free goods as part of the Temporary Patient Assistance Program (TPAP), or to enroll a eligible commercially insured patient who can pay as little as $0 on their out of pocket medication cost. If the request is limited to benefit verification or copay assistance support (which eligible commercially insured patients can pay as little as $0 on their out of pocket medication cost.), the prescriber, or an individual acting at the direction of the prescriber and involved in the patient's care (such as an office practice manager, financial coordinator, financial counselor, patient assistance coordinator, patient navigator, social worker, insurance coordinator, patient coordinator, or patient care advocate) may sign this form.

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 therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for the Ipsen therapy and assisting in initiating or continuing the Ipsen therapy. I authorize Ipsen to be my agent and to forward the above prescription, by fax or other mode of delivery, to the appropriate pharmacy. If required by your state, please provide all prescriptions on an official state prescription form to ensure compliance.

I certify that any medications provided by 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. I acknowledge that I have assisted the named patient in enrolling in IPSEN CARES exclusively for the purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I consent to contact by Ipsen representatives about the program, my patient's participation in the program, or the prescribed medication.

Name* _____ Title _____

Signature* _____ Date* _____

Ipsen respects your privacy and is committed to the confidentiality of the information you choose to share with us. We are collecting your personal information for the purposes described above. Please see Ipsen's US privacy policy at https://www.ipsen.com/us/privacy-policy/ which describes how we process personal information. Residents of certain states have additional rights regarding the collection, use, and disclosure of their personal information. For more information, please see Ipsen's Supplemental State Privacy Notice at https://www.ipsen.com/us/Supplement-Website-Privacy-Notice/. US residents who are unable to review or access this notice due to a disability may call 844-975-1739 to access this notice in an alternative format.

Please see full Prescribing Information, including Medication Guide with IMPORTANT WARNING.