IPSEN CARES™ ENROLLMENT FORM
Information and Insurance Verification

Dysport® (abobotulinumtoxinA)

Fax: 1-888-525-2416 | Phone: 1-866-435-5677

Physician Information

Physician Name **(first and last name)** _____

Practice/Facility Name _____

Specialty ☐ Neurology ☐ Physiatry ☐ Other _____ Medical Education # _____

Street Address _____ City _____

State _____ ZIP _____ Phone # _____ Fax # _____

DEA # _____ PTAN # _____ NPI # _____ LIC # _____ Tax ID # _____

Office Contact Name _____ Phone # _____ Fax # _____

Patient Information

Patient Name **(first and last name)** _____ Date of Birth _____/_____/_____ ☐ Male ☐ Female

Street Address _____ City _____

State _____ ZIP _____ Phone # _____ Fax # _____

Treatment Information

Site of Service ☐ Physician's Office ☐ Hospital Outpatient ☐ Other _____

Prior Therapy ☐ Physical Therapy ☐ Other Botulinum Toxin Type A ☐ Other _____

Diagnosis Code 1 **(required)** _____ EMG Code _____ CPT Code _____ HCPCS _____

Diagnosis Code 2 _____ Date of Service **(if scheduled)** _____

Dysport Dose _____ Units Injection Sites _____

Insurance Information – PRIMARY

(You can submit a copy of the patient's insurance card; attach copy, front and back, instead of completing this section.)

☐ Medicare ☐ Medicaid ☐ Commercial ☐ Workers' Compensation ☐ TRICARE ☐ VA

Name of Insurance Company _____

Phone # _____ Fax # _____

Subscriber's Name _____ Policy # _____ Group # _____

Subscriber's DOB _____/ ____ / _____ Employer's Name _____

Subscriber's ID # _____ Employer's Addres _____

Relationship to Patient _____ Is Physician a Participating Provider (check one)? ☐ Participating ☐ Non-Participating

Insurance Information – SECONDARY

(You can submit a copy of the patient's insurance card; attach copy, front and back, instead of completing this section.)

☐ Medicare ☐ Medicaid ☐ Commercial ☐ Workers' Compensation ☐ TRICARE ☐ VA

Secondary Insurance Name _____ Phone # _____

Subscriber's Name _____ ID # _____ Group # _____

PRESCRIBER ATTESTATION: I certify that any medications received from Ipsen (as defined above) in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

Prescriber Signature _____ Date _____

Please see accompanying Full Prescribing Information, including **Boxed Warning** and Medication Guide.

Questions?

To request a visit from your Dysport® Field Reimbursement Manager, email reimbursementinformation@ipsen.com.

IPSEN CARES™
Coverage, Access, Reimbursement & Education Support

PATIENT AUTHORIZATION

Fax: 1-888-525-2416 | Phone: 1-866-435-5677

Dysport® (abobotulinumtoxinA)

Patient Authorization to Use/Disclose Health Information: IPSEN CARES™ Program

I authorize my healthcare providers (including those pharmacies that may receive my prescription for Dysport®) to disclose personal health information (PHI) about me 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. I understand these parties will use and/or disclose my PHI, only as needed, to enroll me in IPSEN CARES™ to 1) establish my benefit eligibility and potential out-of-pocket costs for Dysport®; 2) communicate with my healthcare providers and health plans about my treatment plan; 3) provide support services, including patient education and financial assistance for Dysport®; 4) help get Dysport® shipped to my healthcare provider; 5) evaluate the effectiveness of Ipsen's support programs and conduct market analysis, including aggregating my health information with other data for such analyses; and 6) provide assistance with my enrollment into the Dysport® Copay Assistance program (if applicable). I understand that Ipsen may also contact me to solicit my opinions about IPSEN CARES™ services. I agree that using the contact information I provide, Ipsen may get in touch with me for reasons related to the IPSEN CARES™ program and support services and may leave messages for me that may disclose that I am on Dysport® 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 may experience. Similarly, I consent to a program representative contacting my doctor or other healthcare professional for the same purpose. I understand that once my PHI has been disclosed to Ipsen, privacy laws may no longer restrict its use or disclosure; however, Ipsen agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. I understand that my healthcare providers may receive remuneration from Ipsen in exchange for my PHI and/or for any therapy support services provided to me. I further understand that I may refuse to sign this authorization and if I do not sign it, my eligibility for health plan benefits and treatment will not change, but I will not have access to IPSEN CARES™ program support as described above. I may revoke (cancel) this authorization at any time by mailing a letter requesting such revocation to IPSEN CARES™, 11800 Weston Parkway, Cary, NC 27513, or by calling 1-866-435-5677.

Patient Name _____ Parent/Legal Guardian Name _____

Relationship to Patient _____

Signature _____ Date _____

Additional Support and Patient Program Participation

In addition to participating in the IPSEN CARES™ program described above, I authorize Ipsen to enroll me directly in Dysport® patient programs, including any financial assistance programs for which I may be eligible. I understand that my personally identifiable information related to treatment with Dysport® is required for participation in the support programs. I understand that any personal information that I have provided will be shared between IPSEN CARES™ and the Dysport® patient programs. I would also like to receive additional support from Ipsen, which may include receiving marketing and educational information about Dysport® and programs that support patients.

I understand that my personally identifiable information (including name, address, phone number, and/or email) will be shared with Ipsen, its agents and affiliates, and my healthcare provider. I agree that I may be contacted in the future by mail, email, and/or telephone concerning the Dysport® patient programs.

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 my authorization to receive additional support and product information at any time. This authorization is valid until December 31, 2028. To revoke this authorization, please call 1-866-435-5677 or send your request in writing to: IPSEN CARES™, 11800 Weston Parkway, Cary, NC 27513.

Patient Name _____ Parent/Legal Guardian Name _____

Relationship to Patient _____

Signature _____ Date _____

Please **Click Here** for Full Prescribing Information including **Boxed Warning,** and Medication Guide for Dysport®.

IPSEN CARES™
Coverage, Access, Reimbursement & Education Support
www.ipsencares.com

IPSEN
Innovation for patient care