Questions? Call IPSEN CARES at 866.435.5677

Patient Financial Support Application

Fax Completed Form To:
888.525.2416

The DYSPORT Patient Assistance Program (PAP) is designed to provide DYSPORT 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 meet specific medical criteria as supported by information provided in the Program application. Eligibility does not guarantee approval for participation in the program. The DYSPORT PAP provides DYSPORT (abobotulinumtoxinA) product only, and does not cover the cost of previously purchased product or medical services.

Instructions: Both the patient and the healthcare provider have to complete the application.

PATIENT REQUIREMENTS

- **Complete and sign the Patient Information section, including the Financial Information section.**
- **If you are seeking financial assistance from the PAP, please fax a copy of proof of total household income. Accepted forms include most recently filed Federal Tax Forms (i.e., Form 1040) including supporting documents (W-2), social security income (SSA 1099), or the completed Notarized Income Statement form included at the end of this application.**

HEALTHCARE PROVIDER REQUIREMENTS

- **Complete and sign the Healthcare Provider Information section.**
- **Verify that the patient is being prescribed and administered DYSPORT.**
- **Ensure the entire application is complete and signed before sending it to the fax number provided above.**

It is important that you and your healthcare provider complete all requested information and sign where indicated. Since incomplete or incorrect applications will delay the application process, please ensure all information provided is correct.

We recommend that you fax the completed form in order to expedite the process. Once the application is received, we will evaluate the patient's eligibility to participate in the DYSPORT PAP. Healthcare providers will be notified upon completion of eligibility review. Please note that program rules are subject to change without notice. For further assistance, please call (866) 435-5677 from 8:00 AM to 8:00 PM Eastern Time, Monday through Friday.

Important Safety Information

Dysport® (abobotulinumtoxinA) may cause serious side effects that can be life threatening, including problems breathing or swallowing and spread of toxin effects. These problems can happen within hours, or days to weeks after an injection of Dysport. Deaths due to these problems have occurred. Call your doctor or get medical help right away if you have any of these problems after treatment with Dysport:

Problems swallowing, speaking, or breathing. This is usually because the muscles used to breathe and swallow can become weak after the injection. Death can happen if you have severe problems with swallowing or breathing after treatment with Dysport. People who already have problems with swallowing or breathing before receiving Dysport have the highest risk of getting these problems.

Spread of toxin effects. In some cases, the effects of botulinum toxin may affect areas of the body away from the injection site and cause symptoms of a serious condition called botulism. The symptoms of botulism include loss of strength and muscle weakness all over the body, double vision, blurred vision and drooping eyelids, hoarseness or change or loss of voice (dysphonia), trouble speaking (dysarthria), loss of bladder control, trouble breathing, or trouble swallowing. These problems could make it unsafe for you to drive a car or do other dangerous activities.

What is Dysport?

Dysport is a prescription medicine that is injected into muscles and used to treat the abnormal head position and neck pain that happens with cervical dystonia (CD) in adults.

It is not known whether Dysport is safe or effective in children under 18 years of age. It is not known whether Dysport is safe or effective for the treatment of other types of muscle spasms.

Do not take Dysport if you are allergic to Dysport or any of the ingredients in Dysport (See Medication Guide for ingredients), or are allergic to cow's milk protein, had an allergic reaction to any other botulinum toxin product, such as Myobloc® (rimabotulinumtoxinB), Botox® (onabotulinumtoxinA), or Xeomin® (incobotulinumtoxinA), or have a skin infection at the planned injection site.

Tell your doctor about all your medical conditions, such as diseases that affect your muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease], myasthenia gravis, or Lambert-Eaton syndrome), as you may be at increased risk of serious side effects, including severe dysphagia (difficulty swallowing) and respiratory problems (difficulty breathing) from normal doses of Dysport.

Tell your doctor if you have or have had any of the following: allergies to any botulinum toxin product, side effect(s) from any botulinum toxin product in the past, breathing problems (such as asthma or emphysema), swallowing problems, bleeding problems, diabetes, slow heartbeat, or other problems with your heart rate or rhythm.

Tell your doctor if you are pregnant, plan to become pregnant, or are breast-feeding or planning to breast-feed. It is not known if Dysport can harm your unborn baby. It is not known if Dysport passes into breast milk.

Tell your doctor about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal products. Using Dysport with certain other medicines may cause serious side effects. Do not start any new medicines until you have told your doctor that you have received Dysport in the past.

Especially tell your doctor if you have received injections of botulinum toxin, such as Myobloc®, Botox®, or Xeomin®, in the past; have recently received an antibiotic by injection; take muscle relaxants; take an allergy or cold medicine; or take a sleep medicine. Be sure your doctor knows exactly which product you received.

Other side effects of Dysport include dry mouth, injection site discomfort or pain, tiredness, headache, neck pain, muscle pain, and eye problems, such as double vision, blurred vision, decreased eyesight, problems with focusing the eyes (accommodation), drooping eyelids, and swelling of the eyelids.

Symptoms of an allergic reaction to Dysport may include itching, rash, red itchy welts, wheezing, asthma symptoms, or dizziness or feeling faint. Tell your doctor or get medical help right away if you get wheezing or asthma symptoms, or if you get dizzy or faint.

Tell your doctor if you have any side effect that bothers you or that does not go away. These are not all the possible side effects of Dysport. For more information, ask your doctor or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1–800–FDA–1088.

The Medication Guide summarizes the most important information about Dysport. If you would like more information, talk with your doctor. Full Product Information, including Boxed Warning, and Medication Guide, has been provided to your doctor.

For more information about Dysport, call 1-855-463-5127 or go to www.dysport.com.

Please click here to see DYSPORT Medication Guide that includes a WARNING about possible side effects that may include problems with breathing or swallowing.

Sincerely,

The IPSEN Coverage, Access, Reimbursement & Education Support (CARES) program

IPSEN CARES
Coverage, Access, Reimbursement & Education Support

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PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE PATIENT

First Name ______________________ MI ____________ Last Name ________________
Date of birth (MM/DD/YYYY)_____/_____/_____
Mailing Address ____Apt # __________
City______________________________State_______________________Zip__________
Social Security Number ____________________Gender ☐ Male ☐ Female
Daytime Phone Number (___)_____________Evening Phone Number (_________) _________
Email Address______________________________ Are you a US Citizen or legal US resident? ☐ Yes ☐ No
Prescribing Physician ______________________Treating Facility ______________________

ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

My estimated annual household income currently is $ ______________
(Please include dollar amount of monthly income from)

- $__________Social Security Disability Income (SSDI) (beginning_______/_____)
- $__________Supplemental Security Income (SSI)
- $__________Aid from the Department of Public Welfare
- $__________Unemployment Benefits (from______/______ to _____/_____)
- $__________Workers Compensation Benefits (from_____/_____ to _____/_____)
- $__________Dividends, interest, or investment accounts
- $__________Employment (myself and/or my spouse)
- $__________Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household ______________

Insurance Type	Status	Effective Date	Please indicate Primary(P) or Secondary(S)
Commercial	☐ Approved ☐ Denied ☐ Waiting for Decision	____/____/____	
Medicaid	☐ Approved ☐ Denied ☐ Waiting for Decision	____/____/____	
Medicare	☐ Approved ☐ Denied ☐ Waiting for Decision	____/____/____	
TriCare	☐ Approved ☐ Denied ☐ Waiting for Decision	____/____/____	
Healthcare Exchange	☐ Approved ☐ Denied ☐ Waiting for Decision	____/____/____	
Other	☐ Approved ☐ Denied ☐ Waiting for Decision	____/____/____	
☐ Uninsured	Patient is not eligible for any public health insurance, which includes Medicare and Medicaid, or has been denied coverage by a third-party payer.		

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health ("Health Information") to Ipsen Biopharmaceuticals, Inc., and/or its agents or third party vendors ("Ipsen") and the DYSPORT® Patient Assistance Program (the "PAP"). I know that the information I provide will be used by the PAP to decide if I am eligible for assistance, operate the PAP, send me information about the PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance, and/or medical information, and share my information as required or permitted by law. I give permission to 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 my Health Information 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; my doctor(s) and other people, or institutions who are involved in my healthcare, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information, that I provide to PAP are complete and true, and unless I have said something different in this application, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health 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 may revise, change, or terminate this program at any time. All information that I provide may be used by Ipsen, or any third party working on behalf of Ipsen, in connection with the PAP. Ipsen and its third-party partners will keep my information confidential in accordance with all applicable US laws, rules, and regulations.

Patient Signature ____Date ______________

HEALTHCARE PROVIDER INFORMATION: THIS SECTION MUST BE COMPLETED BY THE PRESCRIBING PHYSICIAN

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 ☐ Endocrinologist ☐ Other______________Preferred method of contact ☐ Phone ☐ Fax ☐ Email

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 ______________

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INCOME REQUIREMENTS Use this form only if you cannot provide proof of income documentation.

Patient Name ______________________ Social Security Number ____________ Date of birth (MM/DD/YYYY) ____/____/____

My estimated annual household income currently is $ ______________________

(Please include dollar amount of monthly income from)

- $______________ Social Security Disability Income (SSDI) (beginning______/______)
- $______________ Supplemental Security Income (SSI)
- $______________ Aid from the Department of Public Welfare
- $______________ Unemployment Benefits (from______/______ to ______/______)
- $______________ Workers Compensation Benefits (from ___/___ to ______/______)
- $______________ Dividends, interest, or investment accounts
- $______________ Employment (myself and/or my spouse)
- $______________ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household ______________________

Patient Signature ______________________________________ Date ______________

THIS FORM MUST BE NOTARIZED IN ORDER TO PROCESS YOUR APPLICATION

State of ______________________ County of ______________

______________________ sworn and subscribed to me on this ___ day of ________ as to the completeness and truthfulness of the information contained herein.

(Patient Name)

Signature of Notary ______________________

NOTARY SEAL

My commission expires ______________________

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