Patient Financial Support Application

Fax Completed Form To
888.525.2416

The INCRELEX Patient Assistance Program (PAP) is designed to provide INCRELEX 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 INCRELEX PAP provides INCRELEX (mecasermin [rDNA origin] injection) product only, and does not cover the cost of previously purchased product or medical services.

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

PATIENT/ GUARDIAN 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 INCRELEX.
- 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 INCRELEX 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. Please see INCRELEX full Prescribing Information at www.increlex.com.

Sincerely,

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

Questions? Call IPSEN CARES at 866.435.5677

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PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE PATIENT/GUARDIAN

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 ____________
Patient/Guardian name and relationship to patient ____________

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 have authority and give permission for my doctor(s) and their staff to disclose the patient's personal information, including information about insurance, prescription, medical condition, and health ("Health Information") to Ipsen Biopharmaceuticals, Inc. ("Ipsen") and the INCRELEX Patient Assistance Program (the "PAP"). I know that the information I provide will be used by the PAP to decide if the patient is eligible for assistance, operate the PAP, send me information about the PAP and other programs that might help me pay for the patient's medicines; send information to other programs that might help me pay for the patient's medicines; ask me for financial, insurance, and/or medical information, and share my information and the patient's 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 the patient's 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 the Program 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 Biopharmaceuticals, Inc., 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 or Guardian 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 registered 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 ______

Questions? Call IPSEN CARES at 866.435.5677

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

Parent/Guardian 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________________________________

My commission expires________________________________

NOTARY SEAL

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