Questions? Call IPSEN CARES at 866.435.5677

Somatuline® Depot (lanreotide) Injection

Patient Financial Support Application

Fax Completed Form To:
888.525.2416

The SOMATULINE DEPOT Patient Assistance Program (PAP) is designed to provide SOMATULINE DEPOT 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 SOMATULINE DEPOT PAP provides SOMATULINE DEPOT (lanreotide injection) 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 SOMATULINE DEPOT.
- 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 SOMATULINE DEPOT 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 SOMATULINE DEPOT full Prescribing Information at www.somatulinedepot.com.

Sincerely,

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

IPSEN CARES
Coverage, Access, Reimbursement & Education Support

Questions? Call IPSEN CARES at 866.435.5677

Somatuline® Depot (lanreotide) Injection

Patient Financial Support Application

Fax Completed Form To:
888.525.2416

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. ("Ipsen") and the SOMATULINE® DEPOT 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 _____

Questions? Call IPSEN CARES at 866.435.5677

Somatuline® Depot (lanreotide) Injection

Patient Financial Support Application

Fax Completed Form To:
888.525.2416

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 _____

My commission expires _____

NOTARY SEAL