onivyde® (irinotecan liposome injection)

Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416

The Patient Assistance Program (PAP) is designed to provide ONIVYDE at no cost to eligible patients. Patients may be eligible to receive free drug if they are experiencing financial hardship, are uninsured or functionally uninsured, are US residents, and received a valid prescription for an on-label use of ONIVYDE as supported by information provided in the program application. Eligibility does not guarantee approval for participation In the program. The PAP provides ONIVYDE product only, and does not cover the cost of previously purchased product or medical services.

Completed by the patient/legal guardian

STEP 1

PATIENT INFORMATION

Patient Name (First & Last) _____

Patient Address _____

City _____

State _____ Zip _____

Date of Birth (MM/DD/YY) ____ / ____ / ____

Email _____

Home Phone # _____

Mobile Phone # _____

Caregiver/Legal Guardian Name (First & Last)

_____

Caregiver/Legal Guardian Phone # _____

Relationship to Patient _____

INSURANCE INFORMATION

Complete the information below or fax a copy of the front and back of patient's primary and secondary insurance cards for pharmacy and medical benefits.

Primary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

Secondary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

Is Physician a Participating Provider (check one) ☐ Participating ☐ Non-Participating

☐ **Uninsured -** Patient does not have commercial health insurance and is not eligible for public health insurance, including but not limited to Medicare or Medicaid, or has been denied coverage by their health insurance.

STEP 2

PROOF OF INCOME*

My estimated annual household income currently is $ _____ Number of people in household _____

***IPSEN CARES will conduct a soft credit check as part of the process of confirming income and determining eligibility for the program.**

STEP 3

THIRD PARTY VERIFICATION AUTHORIZATION

I understand that I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA") authorizing the IPSEN CARES® Patient Assistance Program (the "Program"), Ipsen Biopharmaceuticals, Inc. ("Ipsen"), and its vendor, on an ongoing basis as needed for the duration of my participation in Program, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from a credit reporting agency (including, without limitation, Experian Health), for the purpose of determining financial qualifications and eligibility for programs administered by Ipsen and the Program.

Completed by the patient/legal guardian

STEP 3 (continued)

THIRD PARTY VERIFICATION AUTHORIZATION (continued)

I understand that I am affirmatively agreeing to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare or any public or private assistance program or any other form of insurance. If my income or health coverage changes, I will call the Program at 1-866-435-5677.

Patient/Legal Guardian Signature _____ **Date** _____

STEP 4

PATIENT AUTHORIZATION

I authorize my/the patient's healthcare providers and their staff (including those pharmacies that may receive my prescription for ONIVYDE®) to disclose personal health information ("PHI") about me/the patient, including health information relating to my/the patient's medical condition, prescription, and insurance coverage, 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 on its behalf (collectively "Ipsen") in order for Ipsen to: (1) enroll me/the patient in the IPSEN CARES® Patient Assistance Program (the "PAP") if I/the patient am/is eligible; (2) establish my/the patient's benefit eligibility for assistance related to potential out-of-pocket costs for ONIVYDE®; (3) send me information about the PAP and other programs that might help me/the patient pay for my/the patient's medicines; (4) help get ONIVYDE® shipped to my/the patient's healthcare provider; and (5) facilitate my/the patient's participation in ONIVYDE® patient programs as I have requested or may request.

I agree that, using the contact information I provide, Ipsen may contact me for reasons related to the IPSEN CARES® PAP to (1) determine if I/the patient am/is eligible for assistance and related support services; (2) leave messages for me that may disclose that I/the patient am/is or am not/is not eligible for assistance; (3) operate the PAP and other programs that might help me pay for my/the patient's medicines; (4) send my/the patient's information to other programs that might help me pay for my/the patient's medicines; (5) ask me for financial, insurance, and/or medical information; and/or (6) share my/the patient's information as required or permitted by law. I authorize 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/the patient's PHI 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/the patient's doctor(s) and other people, or institutions who are involved in my/the patient's healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for my/the patient's medication. All information that I provide may be used by Ipsen, or any third party working on behalf of Ipsen, in connection with the PAP. I also consent to being contacted by an IPSEN CARES® program representative to obtain further information or clarification regarding any adverse event I/the patient may experience.

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Completed by the patient/legal guardian

STEP 4 (continued)

PATIENT AUTHORIZATION (continued)

I understand that once my/the patient's PHI has been disclosed to Ipsen, privacy laws may no longer restrict its use or disclosure. However, Ipsen agrees to protect my/the patient's information by using and disclosing it only for the purposes described above or as required. I understand that my/the patient's healthcare providers may receive remuneration from Ipsen in exchange for my/the patient's PHI and/or for any therapy support services provided to me/the patient.

I can withdraw this authorization by calling IPSEN CARES® at 1-866-435-5677 or mailing a letter requesting such revocation to IPSEN CARES®, 11800 Weston Parkway, Cary, NC 27513, but it will not change any actions taken before I withdraw this authorization. Withdrawal of this authorization will end further uses and disclosures of PHI by the parties identified in this form except to the extent those uses and disclosures have been made in reliance upon my authorization. I understand that I may refuse to sign this form and, if I do so, I/the patient will not be able to participate in the PAP, but it will not affect my/the patient's eligibility to obtain medical treatment, my/the patient's ability to seek payment for this treatment or affect my/the patient's insurance enrollment or eligibility for insurance coverage. This authorization expires three years from the date signed unless a shorter time is required by law or unless I revoke my authorization before that time.

I understand that I will receive a copy of the signed authorization. I promise that any information, including financial and insurance information, that I provide to the PAP is complete and true, and unless I have said something different in this application, I have no insurance coverage for this product, 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.

Patient/Legal Guardian Signature _____ **Date** _____

We are collecting personal information in order to fulfill your request. Please see Ipsen's privacy policy at https://www.ipsen.com/us/privacy-policy/.

Completed by the prescriber

STEP 5

PRESCRIBER INFORMATION

Prescriber Name (First & Last) _____

State License # _____

Tax ID # _____ NPI # _____

Medicaid Provider # (Required if Medicaid Patient) _____

Office/Institution _____

Specialty

Street Address _____

City _____ State _____ Zip _____

Office Contact and Title _____

Phone # _____ Fax # _____

Email _____

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening

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Completed by the prescriber

STEP 6

DIAGNOSIS

Primary ICD-10 Code _____ **Secondary ICD-10 Code (optional)** _____

STEP 7A

PRESCRIPTION AND PRESCRIBER ATTESTATION

PRESCRIPTION Onivyde® (irinotecan liposome injection)

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

Site of Care ☐ Physician Office ☐ Hospital/Outpatient ☐ Infusion Center ☐ Other _____

Please fill in the requested information in the table below.

Onivyde Strength	Route of Administration	Frequency	Directions	Quantity	Refills
	Intravenous injection				

STEP 7B

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), or to enroll a patient for free goods as part of the Temporary Patient Assistance Program (TPAP).]

By signing below, I certify that a prescription signed by a licensed prescriber is on file for the above therapy and that the patient named on this form has provided the necessary authorization to release the information herein and medical and/or patient information relating to ONIVYDE® therapy to Ipsen and its agents or contractors for the purpose of evaluating the patient's eligibility for Ipsen's patient support programs administered by IPSEN CARES®. I authorize Ipsen to be my agent and to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the patient named on this form. For the state of New York, copies of all prescriptions should be on official New York state prescription forms. I certify that any medications received from 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. Additionally, no claim for reimbursement will be submitted concerning any medications provided by Ipsen, or any services provided by IPSEN CARES®, to any payor, including Medicare, Medicaid, or any other federal or state health insurance program, nor will any medications be returned for credit. If the named patient does not return for therapy, product will be returned to Ipsen. I acknowledge that I have assisted the patient in enrolling in IPSEN CARES® 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.**

IPSENCARES® Coverage, Access, Reimbursement & Education Support