IPSEN CARES SELF ENROLLMENT FORM

QUESTIONS? CALL IPSEN CARES AT 1-866-435-5677

Somatuline® Depot (lanreotide) Injection 60 mg 90 mg 120 mg

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

IPSEN CARES must receive all pages in order for the Enrollment Form to be complete.

THIS FORM IS TO BE USED TO DETERMINE ELIGIBILITY AND TO ENROLL INTO THE SOMATULINE DEPOT COPAY ASSISTANCE PROGRAM. THIS FORM IS INTENDED FOR PATIENT USE ONLY.

STEP 1

PATIENT INFORMATION

Patient Name (First & Last) _____ Home Phone # _____

Patient Address _____ Mobile Phone # _____

City _____ Caregiver/Legal Guardian Name (First & Last)

State _____ Zip _____ _____

Date of Birth (MM/DD/YY) ____ / ____ / ____ Caregiver/Legal Guardian Phone # _____

Email _____ Relationship to Patient _____

Would you like to enroll in the Ipsen adherence text messaging program as outlined on Page 3, in Step 5 under *Additional Product and Support Information*? I give permission to Ipsen to contact me by SMS/text message for the Ipsen adherence text messaging program. Carrier, text, and data rates may apply. ☐ Yes ☐ No

Would you like to receive marketing information from Ipsen as described on Page 4, in Step 5 under *Additional Product and Support Information*? I give permission to Ipsen to contact me with information via mail, email, phone, or SMS/text message, all of which may include marketing, advertisements, disease state awareness materials and educational material about Somatuline Depot and programs that support patients. Automatic dialing may be used. Carrier, text, and data rates may apply. I understand that I am not required to provide this consent as a condition of purchasing any goods or services. ☐ Yes ☐ No

STEP 2

PRESCRIBER INFORMATION

Prescriber Name _____ Office/Institution _____

Street Address _____

City _____ State _____ Zip _____

Office Contact and Title _____

Office Contact Phone # _____

Diagnosis (optional) _____

STEP 3

INSURANCE INFORMATION

Complete or attach front and back copy of patient's primary and secondary insurance cards for pharmacy and medical benefits.

Is patient insured? ☐ Yes ☐ No Does patient have secondary insurance? ☐ Yes ☐ No

Primary Insurance Co. _____ Secondary Insurance Co. _____

Insurance Co. Phone # _____ Insurance Co. Phone # _____

Subscriber Policy ID # _____ Subscriber Policy ID # _____

Policy/Employer/Group # _____ Policy/Employer/Group # _____

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

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STEP 4

IPSEN CARES COPAY PROGRAM

Eligible patients using commercial insurance can save on out-of-pocket Ipsen medication costs. Please see Patient Eligibility & Terms and Conditions.

I attest that I am not enrolled in any health insurance plan from any state or federally funded programs (including, but not limited to, Medicare or Medicaid, VA, DOD, or TRICARE) and agree to the Terms and Conditions of the Copay Program. ☐ Yes ☐ No

☐ I would like IPSEN CARES to check my eligibility for, and enroll me into, the Somatuline Depot Copay Program if the results of this benefit verification determine that I have commercial or private health insurance.

PATIENT AUTHORIZATION AND ADDITIONAL PRODUCT AND SUPPORT INFORMATION

I have read and understand the IPSEN CARES Patient Authorization and Additional Product and Support Information on Pages 2, 3 and 4, in Step 5 and agree to the terms.

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

STEP 5

PATIENT AUTHORIZATION AND SIGNATURE – IPSEN CARES® PROGRAM

I authorize my healthcare providers (including those pharmacies that may receive my prescription for Somatuline® Depot), to disclose personal health information ("PHI") about me, including health information relating to my 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 in IPSEN CARES®; (2) establish my benefit eligibility and potential out-of-pocket costs for Somatuline® Depot; (3) communicate with my healthcare providers and health plans about my treatment plan; (4) provide support services including patient education and financial assistance for Somatuline® Depot; (5) help get Somatuline® Depot shipped to me or my healthcare providers; (6) evaluate my eligibility for home health administration if requested by my physician; and (7) facilitate my participation in Somatuline® Depot patient programs that I have elected to receive information about, as indicated below. I agree that, using the contact information I provide, Ipsen may contact 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 Somatuline® Depot 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.

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STEP 5 (continued)

PATIENT AUTHORIZATION AND SIGNATURE – IPSEN CARES® PROGRAM (continued)

I understand that once my PHI has been disclosed to Ipsen, it is no longer protected by federal privacy laws and Ipsen may re-disclose it; however, Ipsen has agreed to protect my PHI 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 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 authorization. Withdrawal of 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 will not be able to participate in IPSEN CARES® programs, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment, or affect my 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.

ADDITIONAL PRODUCT AND SUPPORT INFORMATION

Text Adherence Program

To the extent that I have opted in under step one of this form, I agree to be contacted by autodialed text messages (“texts”) at the mobile phone number I have provided below for the purpose of helping me/the patient stay on therapy, which may promote or advertise the Ipsen products included in the therapy plan. I certify that the number I am providing belongs to me and not a family member or third party. I understand that I may opt out of individual communications of the program entirely at any time by calling 866-435-5677 or replying “STOP” by text to any text from Ipsen. Ipsen will not sell or rent this information and will use it only in accordance with this authorization and consent. Consent to being contacted by text messages is not a condition of participation in the IPSEN CARES® programs or the purchase of any products or services. I understand that my cellular service carrier’s data and text messaging rates may apply. Privacy policy at www.ipsencares.com. 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. If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Ipsen harmless in the event that such other person alleges that they did not give consent.

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STEP 5 (continued)

ADDITIONAL PRODUCT AND SUPPORT INFORMATION (continued)

Marketing Information

To the extent that I have opted in under step one of this form, I would like to receive information from Ipsen via mail, email, phone or SMS/text message, all of which may include marketing content, advertisements, disease state awareness materials and educational material about SOMATULINE® DEPOT, and programs that support patients. These text messages and voice calls may be made via the use of automatic telephone dialing systems. I certify that the number I am providing belongs to me and not to a family member or other third party. 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 this authorization to receive additional product information at any time. By signing below, I agree that Ipsen and its agents may use and disclose my personal information (including name, address, phone number, and/or email) to provide these services and Ipsen may also contact me to solicit my opinions regarding SOMATULINE® DEPOT and Ipsen's products and services. I understand that my cell phone carrier's standard rates may apply for calls to my cell phone. 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 may revoke this authorization, by calling 866.435.5677 or sending a request in writing to: IPSEN CARES®, 11800 Weston Parkway, Cary, NC 27513. If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Ipsen harmless in the event that such other person alleges that they did not give consent.

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/.

Please see accompanying full **Prescribing Information** and **Patient Information**.

IPSEN CARES® Coverage, Access, Reimbursement & Education Support