Somatuline Depot Member Reimbursement Form

Submission Fax Number: 253-395-8028

The IPSEN CARES® Copay Assistance Program Patient Reimbursement Form may only be completed by the patient or the patient's authorized representative. This Form may be submitted, along with all required documentation, for the patient to receive reimbursement from the IPSEN CARES Copay Assistance Program for amounts the patient has paid towards the cost of Somatuline Depot, consistent with the Terms and Conditions of the IPSEN CARES Copay Assistance Program. Patient is responsible for any amounts not covered by the Copay Assistance Program.

If the patient has any questions about submitting this claim, the patient or his/her authorized representative should call IPSEN CARES Support at 866-435-5677.

Submission instructions:

1. Fill out sections A, B and C and sign and date Section D.
2. Attach a copy of the Explanation of Benefits (EOB) setting forth the amount the patient's private insurance company indicates the patient is required to pay for Somatuline Depot.
3. Attach an invoice from the treatment provider's office (or Specialty Pharmacy), which includes the following information:
   - Name and Address of treatment provider or Specialty Pharmacy
   - Name and Member ID of Patient
   - Date of Service
   - Somatuline Depot or HCPCS Code
   - Billed Amount for Somatuline Depot
4. Attach proof of payment by the patient to the treatment provider or Specialty Pharmacy for the patient'sout-of-pocket cost for Somatuline Depot (eg, credit card receipt, photocopy of check).
5. You may submit the requested documentation via fax 253-395-8028 or mail to IPSEN CARES Support at the address listed below:
   IPSEN CARES
   11800 Weston Parkway
   Cary, NC 27513

Section A: Patient Information			
Last Name	First Name		
Date of Birth (MM/DD/YYYY)			
Home Address	City	State	Zip
Section B: Provider Information			
Last Name	First Name		
Address	City	State	Zip

Section C: Claim Information		
Member ID	Date of Service	Provider Billed Amount
Please check the box with the mg of Somatuline Depot that you take from Ipsen Biopharmaceuticals:		
☐ 60mg NDC: 15054-1060	☐ 90mg NDC: 15054-1090	☐ 120mg NDC: 15054-1120

Section D: Patient Signature

I certify that, to the best of my knowledge, the information on this reimbursement form is true and correct. By submitting this request, I certifythat I have read the Terms and Conditions of the IPSEN CARES Copay Assistance Program and that I am eligible to receive copay assistance from the Program on the claim I am submitting for reimbursement. I certify that I do not have Government Program insurance, asthat term is defined in the Terms and Conditions of the IPSEN CARES Copay Assistance Program, and that I have paid my treatment provider or Specialty Pharmacy for my share of the cost of Somatuline Depot as determined by my private health insurance company. I understand that I am responsible for reporting receipt of the IPSEN CARES Copay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Copay Assistance Program,as may be required. I authorize the release of any medical information to third parties working on behalf of IPSEN necessary to process this request for Copay Assistance.

Signature	Name	Date

If you need assistance or have any questions, please contact IPSEN CARES at 866-435-5677 Monday through Friday, between 8:00 AM and 8:00 PM ET.

*Patient Eligibility & Terms and Conditions: Patients are not eligible for copay assistance through IPSEN CARES® if they are enrolled in any state or federally funded programs for which drug prescriptions or coverage could be paid in part or in full, including, but not limited to, Medicare Part B, Medicare Part D, Medicaid, Medigap, VA, DoD, or TRICARE (collectively, “Government Programs”), or where prohibited by law. Patients residing in Massachusetts, Minnesota, or Rhode Island can only receive assistance with the cost of Ipsen products but not the cost of related medical services (injection). Patients receiving assistance through another assistance program or foundation, free trial, or other similar offer or program, are not eligible for the copay assistance program during the current enrollment year.

For patients with commercial insurance, the maximum copay benefit amount per prescription is an amount equal to the difference between the annual maximum copay benefit of $20,000 and the total amount of copay benefit provided to the patient in the Somatuline® Depot Copay Program.

Patient or guardian is responsible for reporting receipt of copay savings benefit to any insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled through the program, as may be required. Additionally, patients may not submit any benefit provided by this program for reimbursement through a Flexible Spending Account, Health Savings Account, or Health Reimbursement Account. Ipsen reserves the right to rescind, revoke, or amend these offers without notice at any time. Ipsen and/CoverMyMeds, are not responsible for any transactions processed under this program where Medicaid, Medicare, or Medigap payment in part or full has been applied. Data related to patient participation may be collected, analyzed, and shared with Ipsen for market research and other purposes related to assessing the program. Data shared with Ipsen will be de-identified, meaning it will not identify the patient. Void outside of the United States and its territories or where prohibited by law, taxed, or restricted. This program is not health insurance. No other purchase is necessary.

SOMATULINE DEPOT is a registered trademark of Ipsen Pharma S.A.S
IPSEN CARES is a registered trademark of Ipsen S.A.
©2022 Ipsen Biopharmaceuticals, Inc. March 2022 MP-US-000554 V2.0

IPSENCARES®
Coverage, Access, Reimbursement & Education Support

Confidentiality Notice: The documents accompanying this transmission may contain health information from IPSEN Coverage, Access, Reimbursement & Education Support (IPSEN CARES®) program that is legally confidential and/or privileged. This information is intended for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. If you no longer wish to receive mailing from IPSEN CARES®, please contact (866) 435-5677 to opt out.