IPSEN CARES® Patient Enrollment Form

OVERVIEW

The IPSEN CARES individualized support program is a confidential and voluntary program. IPSEN CARES provides disease and treatment education and assists appropriate patients with gaining access to Ipsen product, as prescribed, throughout the patient's treatment journey.

IPSENCARES®
Coverage, Access, Reimbursement & Education Support

Please note that some IPSEN CARES program offerings may only be available with the consent of the patient's healthcare provider and/or after a confirmed diagnosis or prescription.

HOW TO ENROLL IN THE IPSEN CARES PROGRAM

INSTRUCTIONS FOR PATIENTS/CAREGIVERS

- You will need to complete **STEPS 1-4** outlined in **blue** on pages 2-6 of the Enrollment Form.
- Fill out all sections completely. Please be sure that **all fields marked with an asterisk** are filled out, as that information is required for enrollment in the IPSEN CARES program.
  - ☑ **STEP 1:** Fill out the Patient Information Section.
  - ☑ **STEP 2:** Fill out the Insurance Information Section.
  - ☑ **STEP 3:** Sign the **PATIENT AUTHORIZATION** after you read the information on page 4.
  - ☑ **STEP 4:** Sign the **CONSENT FOR USE OF GENETIC INFORMATION**, after you read the information on pages 5-6.
- There are 2 options for returning this form:
  1. You can scan and email the completed form to support@ipsencares.com, or
  2. You or your healthcare provider can fax the completed form to 650-243-5193.

TO BE COMPLETED BY THE PATIENT/CAREGIVER

If you have questions, please call 844-484-1234, Monday – Friday, 8 am – 8 pm ET.

Completed by the Patient/Caregiver

STEP 1 — PATIENT INFORMATION

Patient Name (First & Last)*_____

Patient Address*_____

City*_____ State*____ Zip*_____

Sex: ☐ Male ☐ Female ☐ Other/Undisclosed

Date of Birth (MM/DD/YY)*_____ /_____ /_____

Email (Required if opting in to email) _____

Phone #* (_____) _____ - _____

Preferred method of contact: ☐ Email ☐ SMS (text) ☐ Phone

☐ Consented by Other

Parent/Legal Guardian Name (First & Last)

_____

Required if patient is under 18 years of age.

Parent/Legal Guardian Contact Phone #

(_____) _____ - _____

Required if patient is under 18 years of age.

Relationship to Patient_____

☐ I authorize Ipsen to share my personal health information (PHI) and to discuss my case history and treatment plan, including my PHI, with the individual(s) named below for the sole purpose of facilitating my treatment.

Name_____

Relationship to Patient_____

Email _____

Phone # (_____) _____ - _____

Name_____

Relationship to Patient_____

Email _____

Phone # (_____) _____ - _____

Name_____

Relationship to Patient_____

Email _____

Phone # (_____) _____ - _____

STEP 2 — INSURANCE INFORMATION

Is patient insured?* ☐ Yes ☐ No

Primary Insurance Co. _____

Insurance Co. Phone # (_____) _____ -_____

Subscriber Policy ID # _____

Policyholder same as patient? ☐ Yes ☐ No

Policyholder Name* _____

Policyholder Date of Birth (MM/DD/YY) _____ /_____ /_____

Policy/Employer/Group # _____

Does patient have secondary insurance? ☐ Yes ☐ No

Secondary Insurance Co. _____

Insurance Co. Phone # (_____) _____ - _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

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 IPSEN CARES Copay Program if the results of this benefit verification determine that I have commercial or private health insurance.

Patient/Caregiver Section continued on next page.

Completed by the Patient/Caregiver

STEP 3

PATIENT AUTHORIZATION

Consent to Receive Text Messages, Voice Calls, and Emails

Ipsen may offer certain support services via text message, voice calling, and email. These may include educational materials and information about programs that support patients for the purpose of helping you/the patient stay on your prescribed therapy. If you agree to receive texts, voice calls, and email at the phone numbers and email you have provided, check the appropriate boxes below. By checking these boxes, you are certifying that the phone numbers and email belong to you and not a family member or other third party.†

Do you agree to be contacted by **text messages** ("texts")?* ☐ Yes ☐ No

Do you agree to be contacted by **voice calls**?* ☐ Yes ☐ No

Do you agree to be contacted by **email**?* ☐ Yes ☐ No

Do you agree to be contacted by **mail**?* ☐ Yes ☐ No

Consent to Receive Marketing Information

Ipsen may share marketing information via mail, text message, or email. This may include telemarketing, advertisements, disease state awareness materials, and educational materials about Ipsen products and programs that support patients. If you agree to receive mail, texts, or email marketing information from Ipsen, check the box below. Please note that you are not required to provide this consent in order to receive support from the IPSEN CARES program or as a condition of purchasing any goods or services.†

Do you agree to receive **marketing information**?* ☐ Yes ☐ No

Consent for Use of Personal Health Information

NOTE: *If you are providing this consent on behalf of the patient, your signature will certify that you are authorized to agree as indicated on the patient's behalf, and that references to "you" shall mean "the patient."*

I have read and understand the Patient Authorization for IPSEN CARES on page 4, and agree to the terms.

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

Parent/legal guardian signature is required if patient is under 18 years of age.

†You may opt out of individual communications or the program entirely at any time by calling 844-484-1234 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 the terms set forth in this form. Consent to being contacted by text messages is not a condition of participation in the Support Services programs or the purchase of any products or services. If you do not agree to receive text messages but you nevertheless text IPSEN CARES, IPSEN CARES will respond to your text only to confirm that you have chosen to receive a text.

I understand that my cellular service carrier's data and text messaging rates may apply. I agree that Ipsen may use and disclose my contact information (including name, address, phone number) to provide these services and Ipsen may also contact me to solicit my opinions regarding Ipsen's products and services. Such uses of contact information will be consistent with the Ipsen privacy policy at https://www.ipsen.com/us/privacy-policy/ and the terms set forth in this form.

STEP 4

CONSENT FOR USE OF GENETIC INFORMATION

I have read and understand the Patient Consent Form for Use of Genetic Information on pages 5 and 6, and agree to the terms.

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

Parent/legal guardian signature is required if patient is under 18 years of age.

Ipsen respects your privacy and is committed to the confidentiality of the information you choose to share with us. We are collecting your personal information for the purposes described above. Please see Ipsen's US privacy policy at https://www.ipsen.com/us/privacy-policy/ which describes how we process personal information. Residents of certain states have additional rights regarding the collection, use, and disclosure of their personal information. For more information, please see Ipsen's Supplemental State Privacy Notice at https://www.ipsen.com/us/Supplement-Website-Privacy-Notice/. US residents who are unable to review or access this notice due to a disability may call 844-975-1739 to access this notice in an alternative format.

Completed by the Patient/Caregiver

PATIENT AUTHORIZATION

NOTE: *If you are providing this consent on behalf of the patient, your signature will certify that you are authorized to agree as indicated on the patient's behalf and that references to "you" shall mean "the patient."*

By signing this Patient Authorization Form, I am registering for the IPSEN CARES program, administered by Ipsen Biopharmaceuticals, Inc., its affiliates, employees, contractors, and agents that have been hired or contracted to administer the Support Services program on its behalf (collectively "Ipsen"). This authorization is valid for 1 year from the date the form is signed. 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.

I authorize my healthcare providers (including those pharmacies that may receive my prescription for SOHONOS™ (palovarotene) to disclose personal health information (PHI) about me, including health information relating to my medical condition, prescription, and insurance coverage in order for Ipsen to:

- Enroll me in IPSEN CARES
- Establish my insurance benefit eligibility and potential out-of-pocket costs
- Communicate with my healthcare providers and health plans about my treatment plan
- Provide support services, including patient education and access assistance
- Provide assistance with treatment logistics, including coordination with the specialty pharmacy
- Facilitate my participation in patient programs as I have requested or may request, including coordinating with my caregivers and providing educational support about my condition
- Determine any potential involvement in future patient consulting activities with Ipsen and contacting me in relation to these activities

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 treatment. 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.

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 authorize Ipsen to share my PHI and to discuss my case history and treatment plan, including my PHI, with the individual(s) named below for the sole purpose of facilitating my treatment. I understand that if I am listing other treating healthcare providers here, I may need to follow up with them to complete their authorization process.

Prescribing Physician _____ Phone (____) _____- _____ E-mail _____

Additional Healthcare Providers:

Name _____ Phone (____) _____ - _____E-mail _____

Name _____ Phone (____) _____ - _____E-mail _____

I understand I can withdraw this authorization by calling IPSEN CARES at 844-484-1234 or email such revocation to IPSEN CARES at support@ipsencares.com, 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 (for example, Ipsen will no longer provide assistance accessing insurance benefits, coordinating therapy, or providing disease education), but it will not affect my eligibility to obtain medical treatment, my/the patient's ability to seek payment for this treatment, or affect my insurance enrollment or eligibility for insurance coverage.

Completed by the Patient/Caregiver

CONSENT FOR USE OF GENETIC INFORMATION

NOTE: *If you are providing this consent on behalf of the patient, your signature will certify that you are authorized to agree as indicated on the patient's behalf, and that references to "you" and "your" shall mean "the patient" and "the patient's."*

Your genetic information is protected by laws in your state. That means you have choices about whether to take a genetic test, whether and whom you allow to access genetic information about you, whether you would like your genetic information to be retained for specific purposes, and whether and how you allow the genetic information to be disclosed.

If you wish to participate in IPSEN CARES, please read this consent form carefully.

You may refuse to provide consent to allow us to access or disclose all or some of your genetic information, but your refusal will mean that you cannot participate in IPSEN CARES. Refusal to sign will not affect your eligibility to obtain medical treatment, your ability to seek payment for this treatment, or affect your insurance enrollment or eligibility for insurance coverage. **If you have any questions about the program or wish to withdraw your consent, please call 844-484-1234.**

If we make any substantive changes to the program that impacts the disclosures included in this form, we will provide you with a new consent form and, if required by law, obtain a new consent from you.

Genetic Information

Ipsen will access and retain the following categories of genetic information about you (collectively, your "Personal Genetic Information"): genetic markers.

How We Will Use Your Genetic Information

To the extent necessary to assist you in securing insurance coverage and coordination with the specialty pharmacy for access to the product, the information may be disclosed to your provider of health insurance.

Purposes for Which We Access, Use, and Retain Your Genetic Information

Ipsen may receive the genetic information described above for the following purposes:

- To enroll you in and provide services under the IPSEN CARES
- To facilitate your participation in other patient programs as you have requested or may request
- To comply with legal and regulatory requirements

Disclosure of Your Genetic Information

As noted, Ipsen may disclose your Personal Genetic Information to your provider of health insurance to the extent necessary to assist you in securing insurance coverage for product and to the specialty pharmacy for coordination for your access to the product. Ipsen may also disclose this information to authorized employees and contractors for the purposes identified above. Ipsen may also disclose your genetic information to other third parties, including government agencies, to the extent permissible under applicable state laws.

Ipsen takes reasonable security measures to protect your genetic information from accidental loss and from unauthorized access, use, acquisition, alteration, or disclosure when the genetic information is in transit and at rest. However, once your genetic information has been disclosed by a third party, it may no longer be protected by federal privacy laws and the third party may be permitted to re-disclose it. Therefore, we cannot guarantee that your genetic information will remain confidential after being disclosed to third parties and government agencies. If your genetic information becomes known to others, it may negatively affect your insurability, employability, and social discrimination.

Completed by the Patient/Caregiver

CONSENT FOR USE OF GENETIC INFORMATION (cont'd)

How We Will Store Your Genetic Information

While you are part of IPSEN CARES, Ipsen will retain all genetic information gathered about you in our database. This information will only be accessible to Ipsen staff who need to access it in order to administer, support, or evaluate the program. If you choose to leave, or become ineligible for, the program, the collected genetic information will be archived and not undergo further analysis except to meet our obligations to maintain records of the services offered by our program, to meet legal requirements, and to protect ourselves against legal claims linked to the program. We will retain this information for as long as necessary to meet these objectives and for as long as permitted or required by applicable law.

By signing this form, you direct us to retain your genetic information indefinitely upon completion of the program, subject to the above retention period and your right to withdraw this consent.

Your Rights With Respect to the Genetic Information We Collect About You

You have the right to receive a copy of this consent form signed by you and to access your genetic information. To exercise your rights described under this section, please call 844-484-1234.

California Residents: The California Consumer Privacy Act of 2018 (CCPA) gives California residents certain rights, including the right to know what categories of personal information Ipsen collects about you and the purposes for which such information is collected. More information can be found in our Privacy Policy available at https://www.ipsen.com/us/privacy-policy/. California residents who are unable to review or access this notice due to a disability may call 844-975-1739 to access this notice in an alternative format.

Colorado, Iowa, Illinois, Oklahoma, Maine, Michigan, New Jersey, New Mexico, South Carolina, and Wyoming Residents: You also have the right to correct genetic information about you and to request that we do not disclose your genetic information to any third parties except those necessary for Ipsen to fulfill its legal obligations.

Oregon Residents: By signing this form, you direct us to retain your genetic information upon completion of the program, subject to the above retention period. You also have the right to request that we not use your genetic information for anonymous or coded genetic research purposes and to request that we destroy the genetic information about you at any time.

Please see full Prescribing Information, including Medication Guide with IMPORTANT WARNING.

Questions? Call IPSEN CARES at 844-484-1234.