IPSEN CARES ENROLLMENT FORM

Questions? Call IPSEN CARES at 1-866-435-5677

TAZVERIK® (tazemetostat) tablets 200 mg

Please fill out this form completely, have both the physician and patient sign, and fax to: 1-833-437-1437

Completed by the prescriber

STEP 1

Please check all support options for which the patient is applying:

Quick Start Program Bridge Supply Program Patient Assistance Program (PAP)

Copay Assistance Program

- For patients with commercial (private) coverage that covers TAZVERIK® (tazemetostat)
- Only prescribers and approved pharmacy networks can register patients for this program
- Healthcare providers can visit the TAZVERIK Copay Portal at https://portal.trialcard.com/ipsen

Completed by the patient/legal guardian

STEP 2

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 ____________________

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 TAZVERIK 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 3

INSURANCE INFORMATION

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

Primary Insurance Co. ____________________

Insurance Co. Phone # ____________________

Subscriber Policy ID # ____________________

Policy/Employer/Group # ____________________

Secondary Insurance Co. ____________________

Insurance Co. Phone # ____________________

Subscriber Policy ID # ____________________

Policy/Employer/Group # ____________________

Pharmacy Benefit Manager (PBM) Co. ____________________

Phone # ____________________ Insurance ID # ____________________

Group # ____________________ BIN # ____________________ PCN # ____________________

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.

Please fill out this form completely, have both the physician and patient sign, and fax to: 1-833-437-1437

Completed by the patient/legal guardian

STEP 4

PROOF OF INCOME (required for PAP Enrollment only)*

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 Patient Assistance Program (PAP).**

STEP 5

THIRD PARTY VERIFICATION AUTHORIZATION (required for PAP Enrollment only)

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.

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 6

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: IPSEN CARES® PROGRAM

I authorize my/the patient's healthcare providers (including those pharmacies that may receive my/the patient's prescription for Tazverik®) 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 IPSEN CARES® Patient Assistance Program ("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 Tazverik®; (3) send me information about the PAP and other programs that might help me/the patient pay for my/the patient's Tazverik®; (4) provide support services, including patient education and financial assistance for Tazverik®; (5) help get Tazverik® shipped to my/the patient's healthcare provider; and

Please fill out this form completely, have both the physician and patient sign, and fax to: 1-833-437-1437

Completed by the patient/legal guardian

STEP 6

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: IPSEN CARES® PROGRAM (continued)

(6) facilitate my/the patient's participation in Tazverik® patients 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® program and support services and may leave messages for me that may disclose that I/the patient am/is on Tazverik® 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/the patient may experience.

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 by law. 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 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/the patient will not be able to participate in IPSEN CARES® programs, 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 the product, which includes Medicare, Medicaid, 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/.

TAZVERIK® (tazemetostat) tablets 200 mg

Please fill out this form completely, have both the physician and patient sign, and fax to: 1-833-437-1437

Completed by the prescriber

STEP 7

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

STEP 8

SPECIALTY PHARMACY

Select one: Onco360 Approved On-site Self-dispensing Pharmacy

TAZVERIK will be delivered to the patient's home unless "Approved On-site Self-dispensing Pharmacy" is selected in this section.

STEP 9

DIAGNOSIS

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

STEP 10

PRESCRIPTION AND PRESCRIBER/OFFICE MANAGER ATTESTATION

(Attach a separate prescription if this section does not comply with your state's prescription law.)

PRESCRIPTION TAZVERIK (tazemetostat) 200 mg tablets

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

Please fill in the requested information in the table below.

TAZVERIK Strength	Route of Administration	Frequency	Directions	Quantity	Refills
	Oral				

PRESCRIBER/OFFICE MANAGER 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 Tazverik® therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for Tazverik® therapy, assisting in initiating or continuing Tazverik® therapy, and/or 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.

Name (First & Last) ____________________ Title ____________________

Signature ____________________ Date ____________________

TAZVERIK is a registered trademark of Epizyme, Inc., an Ipsen Company.
IPSEN CARES is a registered trademark of Ipsen S.A.
©2023 Ipsen Biopharmaceuticals, Inc. March 2023 TAZ-US-000829

Please read the full **Prescribing Information**, including Medication Guide for TAZVERIK.

IPSENCARES® Coverage, Access, Reimbursement & Education Support