

PACESM Enrollment Form Information and Insurance Verification

Fax: 1-888-525-2417

Requestor Information

 Physician Office Manager Nurse Other

Requestor Name (first and last name) _____ Phone # _____ Fax # _____

Physician Information

Physician Name (first and last name) _____ Practice/Facility Name _____

Specialty _____ Unique Physician Medical Education Number _____

Street Address _____ City _____ State _____ ZIP _____

Phone # _____ Fax # _____

DEA # _____ PTAN # _____ NPI # _____ LIC # _____ Tax ID # _____

Patient Information

Patient (first and last name) _____ Date of Birth ____/____/____ Male Female

Street Address _____ City _____ State _____ ZIP _____

Home Phone # _____

Treatment Information

Site of Service: Physician's Office Hospital Outpatient Other: _____Prior Therapy: Physical Therapy Other Botulinum Toxin Type A Other: _____

Diagnosis Code 1 (required) _____ EMG Code _____ CPT Code _____ HCPCS _____

Diagnosis Code 2 _____ Date of Service (if scheduled) _____

Dysport Dose _____ Units Injection Sites _____

Insurance Information – PRIMARY (attach copy, front and back, of patient insurance card)

 Medicare Medicaid Commercial Workers' Compensation TriCARE VA

Name of Insurance Company _____

Address _____ City _____ State _____ ZIP _____

Phone # _____ Fax # _____

Subscriber's Name _____ Policy # _____ Group # _____

Subscriber's DOB ____/____/____ Employer's Name _____

Subscriber's ID# _____ Employer's Address _____

Relationship to Patient _____ Is physician a participating provider (check one)? Participating Non-Participating

Insurance Information – SECONDARY (attach copy, front and back, of patient insurance card)

 Medicare Medicaid Commercial Workers' Compensation TriCARE VA

Secondary Insurance Name _____ Phone # _____

Subscriber's Name _____ ID # _____ Group # _____

ATTENTION—Information Needed: Patient Consent Form Received: Yes No

(Do not process this request until patient consent has been obtained)



Dysport[®]
abobotulinumtoxinA for Injection



PACESM
Patient Access, Care, and Education

PACESM Enrollment Form Patient Consent

Patient Authorization to Use/Disclose Health Information

I authorize my healthcare providers (including those specialty pharmacies that receive my prescription for Dysport) and my health plans to disclose personal and medical information about me to Tercica, Inc. (a subsidiary of the Ipsen Group), its agents and contractors including nursing agencies who work with the PACE program (collectively "Ipsen") to enroll me in the Patient Access, Care, & Education (PACE) program to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my medical care; (3) provide support services, including patient education and helping to get Dysport to me; and (4) evaluate the effectiveness of Ipsen's educational programs and to conduct market analysis, including aggregating my health information (with personally identifying information deleted) with other data for such analysis. I agree that using the contact information I provide, Ipsen may get in touch with me for reasons related to the PACE program and may leave messages for me that may disclose that I take Dysport.

I understand that once my health information has been disclosed to Ipsen, privacy laws may no longer restrict its use or disclosure; however, Ipsen agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. I further understand that I may refuse to sign this Authorization and if I do not sign it, my eligibility for health plan benefits and treatment (including the receipt of Dysport) will not change, but I will not have access to the PACE program support services described above.

I may revoke (cancel) this Authorization at any time by mailing a letter requesting such revocation to: PACE c/o Ipsen, 2000 Sierra Point Parkway, Suite 400, Brisbane, CA 94005. If I cancel, Ipsen will stop using or disclosing my information for the purposes licensed above, except as required by law or as necessary for the orderly termination of my participation in the PACE program. However, revoking this Authorization will not affect the ability of Ipsen to use and disclose information that it has already received.

I understand that I am entitled to a copy of this Authorization, which expires on December 31, 2028.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

Date of Birth

Legal Representative's Relationship to Patient (if applicable)

Patient Programs Participation

I authorize Ipsen to enroll me in Dysport patient programs. I understand that my personally identifiable information related to treatment with Dysport is required for participation in the support program. In addition to the information that I provide directly to the program, I understand that any personal information that I have provided will be shared between PACE and the Dysport patient programs.

I understand that my personally identifiable information will be shared with Ipsen, their agents and affiliates, and my healthcare provider. I agree that I may be contacted in the future by mail, e-mail, and/or telephone concerning the Dysport patient programs. The information you provide to us will be shared with and among our business partners, affiliates, and agents to provide you with information, products, programs, and services, and to conduct market research.

I understand that I do not have to sign this authorization in order to receive Dysport or to be eligible for the assistance from the PACE program and that I may cancel this authorization at any time by mailing a letter to Dysport Patient Programs, 2000 Sierra Point Parkway, Suite 400, Brisbane, CA 94005, by calling 888-525-2423.

This Authorization expires December 31, 2028.

Patient Signature

Date

Patient E-mail

Patient Primary Phone #

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