IPSEN CARES® PATIENT AUTHORIZATION FORM

Questions? Call IPSEN CARES at [NUMBER]

Please print the form, fill it out completely, sign it, and fax to: [NUMBER]
IPSEN CARES must receive all pages in order for the form to be complete.

PLEASE BE SURE TO REVIEW THE ORIGINAL IPSEN CARES ENROLLMENT FORM

Dysport® (abobotulinumtoxinA)

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

I authorize my/the patient's doctor(s) and their staff (including those pharmacies that may receive my/the patient's prescription for Dysport®) to disclose my/the patient's protected health information ("PHI"), including health information about insurance, prescription, care management, and medical condition to Ipsen Biopharmaceuticals, Inc., and/or its affiliates, and/or its agents or third-party vendors that have been hired to administer the Ipsen Coverage, Access, Reimbursement & Education Support (IPSEN CARES) program (collectively, "Ipsen") in order for Ipsen to (1) enroll me/the patient in IPSEN CARES; (2) establish my/the patient's benefit eligibility and potential out of pocket costs for Dysport; (3) communicate with my/the patient's doctors and health plans about my/the patient's treatment plan; (4) provide support services, including patient education and financial assistance for Dysport; (5) help get Dysport shipped to me/the patient or my healthcare provider; and (6) facilitate my/the patient's participation in Dysport patient programs as I have requested or may request, including the IPSEN CARES Patient Assistance Program (the "PAP") if applicable. I agree that, using the contact information I provide, Ipsen may contact me/the patient by phone, mail, and/or email for reasons related to the IPSEN CARES program and support services, including (1) determining if I/the patient am/is eligible for assistance and related support services, (2) leaving messages for me that disclose that I/the patient am/is on Dysport therapy and/or applied for IPSEN CARES support services and am/is or am not/is not eligible for assistance; (3) operating Ipsen Cares patient programs that might help me pay for or access my/the patient's medicines; and (4) confirming receipt of medications. 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 also give Ipsen permission to share my/the patient's PHI and other information with people and companies that work with IPSEN CARES, including insurance providers; my/the patient's doctor(s) and other people, or institutions who are involved in my/the patient's healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for my/the patient's medication. All information that I provide may be used by Ipsen or any third party working on behalf of Ipsen in connection with IPSEN CARES. I understand that my/the patient's healthcare providers may receive remuneration from Ipsen in connection with my/the patient's PHI and/or for any therapy support services provided to me/the patient.

I understand that once my/the patient's 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 make reasonable efforts to protect my/the patient's PHI by using and disclosing it only for the purposes described above or as required by law. I can withdraw this authorization by contacting IPSEN CARES at [NUMBER] or mailing a letter requesting such revocation to IPSEN CARES, 2250 Perimeter Park Dr. Suite 300 Morrisville, NC 27560, but it will not change any actions taken before I withdraw this authorization. Withdrawal of this 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 this authorization.

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

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, 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 confirm that any information, including financial and insurance information, that I provide to IPSEN CARES is complete and true, and unless I have said something different in this application, I have no insurance coverage for this product, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health insurance coverage changes, I will immediately notify IPSEN CARES at [NUMBER]. I confirm that I/the patient am/is a resident of the United States (including its territories). I understand that Ipsen may revise, change, or terminate this program at any time without notice.

ADDITIONAL PRODUCT AND SUPPORT INFORMATION

Text Communications

To the extent that I have opted in by checking the box below this paragraph, I agree to be contacted by autodialed text messages ("texts") at the mobile phone number I have provided for the purpose of helping me/the patient stay on therapy, which may promote or advertise the Ipsen products included in the therapy plan, and/or which may include provision of educational materials and information about programs that support patients. 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 or all text communications entirely at any time by calling [NUMBER] 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. 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. ☐ Yes ☐ No

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ADDITIONAL PRODUCT AND SUPPORT INFORMATION (continued)

Marketing Information

To the extent that I have opted in by checking the box below this paragraph, I would like to receive information from Ipsen via mail, email, phone or text message, all of which may include marketing content, advertisements, disease state awareness materials and educational material about Dysport®, 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. I agree that Ipsen and its agents may use and disclose my personal information (including name, address, phone number, and/or email) to provide this information and Ipsen may also contact me to solicit my opinions regarding Dysport and Ipsen's products and services. I understand and agree that any information I provide may be used by Ipsen to conduct data analysis and market research, and to develop new programs and resources. I understand that my cell phone carrier's standard rates may apply for calls and texts 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 [NUMBER] or sending a request in writing to: IPSEN CARES, 2250 Perimeter Park Dr. Suite 300 Morrisville, NC 27560. 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. ☐ Yes ☐ No

Patient Name (First & Last) _____

Patient Date of Birth (mm/dd/yy) ____ / ____ / ____

Home Phone # _____ Cell Phone # _____

Caregiver/Legal Guardian Name (First & Last) _____

Caregiver/Legal Guardian Phone # _____ Relationship to Patient _____

Signature of Patient/Legal Guardian _____ 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/. 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/.

Please see accompanying full Prescribing Information, including BOXED WARNING and Medication Guide.

IPSENCARES® Coverage, Access, Reimbursement & Education Support