Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Reset Form

IPSEN CARES
Coverage, Access, Reimbursement & Education Support

Dysport®
(abobotulinumtoxinA)

QUESTIONS? CALL IPSEN CARES AT 1-866-435-5677

HOW TO ENROLL IN IPSEN CARES PATIENT SUPPORT PROGRAM

IPSEN CARES provides a single point of contact for patients and their doctor's office.

Instructions for Patients

- Your Healthcare Provider will complete the Steps Outlined in **Light Green**.
- You need to complete the **Steps 1, 2, and 8** Outlined in **Dark Green** on the Enrollment Form.
- Fill out all sections completely. Missing information could delay your enrollment in IPSEN CARES.

☐ Fill out the **Patient Information** Section in **Step 1**.

☐ Fill out the **Insurance Information** Section in **Step 2**.

☐ Sign the **PATIENT AUTHORIZATION AND ADDITIONAL PRODUCT AND SUPPORT INFORMATION** box under **Step 2** after you read the information in **Step 8**.

Your provider will complete the remainder of the form and fax pages 2, 3, 4, and 5 to IPSEN CARES.

Instructions for Prescribers

☐ Fill out the **Prescriber Information Sections** in **Steps 3-7**.

☐ Sign and date the **PRESCRIBER/OFFICE MANAGER ATTESTATION** at the end of **Step 7**.

☐ Fax the completed form to **1-888-525-2416**. IPSEN CARES must receive pages 2, 3, 4, and 5 in order for the Enrollment Form to be complete.

Once a completed Enrollment Form is received, an IPSEN CARES Patient Access Specialist will perform a benefits verification and review the patient's coverage and out-of-pocket responsibility with both the HCP and the patient within 1 business day. To learn more about IPSEN CARES and support offerings, please call 866-435-5677, 8:00 am to 8:00 pm ET Monday through Friday.

IPSEN CARES® ENROLLMENT FORM

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

Dysport® (abobotulinumtoxinA)

Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416

IPSEN CARES must receive pages 2, 3, 4, and 5 in order for the form to be complete.

Completed by the patient

STEP 1

PATIENT INFORMATION

Patient Name (First & Last) _____

Patient Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Date of Birth (MM/DD/YY) ____ / ____ / ____

Email _____

Home Phone # _____

Mobile Phone # _____

Caregiver/Legal Guardian (First & Last Name)

_____

Caregiver/Legal Guardian Phone # _____

Relationship to Patient _____

Would you like to enroll in the Ipsen adherence text messaging program as outlined on Page 5, in Step 8 under *Additional Product and Support Information*? I give permission to Ipsen to contact me by SMS/text message for the Ipsen adherence text messaging program. Carrier, text, and data rates may apply. ☐ Yes ☐ No

Would you like to receive marketing information from Ipsen as described on Page 5, in Step 8 under *Additional Product and Support Information*? I give permission to Ipsen to contact me with information via mail, email, phone or SMS/text message, all of which may include telemarketing, advertisements, disease state awareness materials and educational material about DYSPORT® 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 2

INSURANCE INFORMATION Complete or attach front and back copy of patient's primary and secondary insurance cards for pharmacy and medical benefits.

Is patient insured? ☐ Yes ☐ No

Primary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

Does patient have secondary insurance? ☐ Yes ☐ No

Secondary Insurance Co. _____

Insurance Co. Phone # _____

Subscriber Policy ID # _____

Policy/Employer/Group # _____

Is Physician a Participating Provider? (check one) ☐ Participating ☐ Non-Participating

PATIENT AUTHORIZATION AND ADDITIONAL PRODUCT AND SUPPORT INFORMATION

I have read and understand the IPSEN CARES Patient Authorization and Additional Product and Support Information on Pages 4 and 5, in Step 8 and agree to the terms.

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

Completed by the prescriber

STEP 3

PRESCRIBER INFORMATION

Prescriber Name _____

DEA # _____ State License # _____

Tax ID # _____ NPI # _____

Medicaid Provider # (Required if Medicaid Patient) _____

Medicare PTAN # (Required if Medicare Patient) _____

Office/Institution _____

Specialty ☐ Neurology ☐ Physiatry ☐ Other _____

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 4

PATIENT SUPPORT

Would you like us to provide Temporary Patient Assistance if patient is eligible? ☐ Yes ☐ No

Dysport® (abobotulinumtoxinA)

Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416

IPSEN CARES must receive pages 2, 3, 4, and 5 in order for the form to be complete.

Completed by the prescriber

STEP 5

SPECIALTY PHARMACY AND BUY & BILL

Are you going to utilize Specialty Pharmacy or Buy & Bill? ☐ Specialty Pharmacy ☐ Buy & Bill

Preferred Specialty Pharmacy _____

Was Rx sent to a Specialty Pharmacy already? ☐ Yes ☐ No

If yes, please provide the name of the Specialty Pharmacy _____

STEP 6

STATEMENT OF MEDICAL NECESSITY

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

STEP 7

PRESCRIPTION Dysport® (abobotulinumtoxinA)

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

Site of Care ☐ Physician Office ☐ Hospital/Outpatient ☐ Other _____

Indication	Medication Name and Strength	Route of Administration	Frequency	Directions	Quantity	Refills
☐ **Cervical dystonia**	☐ Dysport Units _____	Intramuscular Injection				
☐ **Adult spasticity**	☐ Dysport Units _____					
☐ **Pediatric spasticity**	☐ Dysport Units _____					

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). If the request is limited to Benefit Verification or Copay Assistance Support, the Prescriber, or an individual acting at the direction of the Prescriber and involved in the patient's care, such as an Office Practice Manager, Financial Coordinator, Financial Counselor, Patient Assistance Coordinator, Patient Navigator, Social Worker, Insurance Coordinator, Patient Coordinator or Patient Care Advocate, may sign this form.)

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 Dysport® therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for Dysport® therapy, assisting in initiating or continuing Dysport® 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.

I certify that any medications received from Ipsen in connection with any IPSEN CARES® program will be used only for the named patient. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning any medications provided by Ipsen, or any services provided by IPSEN CARES®, to any payor, including Medicare, Medicaid, or any other federal or state health insurance program, nor will any medications be returned for credit. If the named patient does not return for therapy, product will be returned to Ipsen. I acknowledge that I have assisted the patient in enrolling in IPSEN CARES® exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

Name _____ Title _____

Signature _____ Date _____

Dysport® (abobotulinumtoxinA)

Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416

IPSEN CARES must receive pages 2, 3, 4, and 5 in order for the form to be complete.

Completed by the patient

STEP 8

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 prescription for Dysport®) 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®; (2) establish my/the patient's benefit eligibility and potential out-of-pocket costs for Dysport®; (3) communicate with my/the patient's healthcare providers 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 my/the patient's healthcare provider; and (6) facilitate my/the patient's participation in Dysport® 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 on Dysport® 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.

Dysport® (abobotulinumtoxinA)

Please print the form, fill it out completely, sign it, and fax to: 1-888-525-2416

IPSEN CARES must receive pages 2, 3, 4, and 5 in order for the form to be complete.

Completed by the patient

STEP 8 (continued)

ADDITIONAL PRODUCT AND SUPPORT INFORMATION

Text Adherence Program

To the extent that I have opted in under step one of this form, I agree to be contacted by autodialed text messages ("texts") at the mobile phone number I have provided below for the purpose of helping me/the patient stay on therapy, which may promote or advertise the Ipsen products included in the therapy plan. 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 of the program entirely at any time by calling 866-435-5677 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. Privacy policy at www.ipsencares.com. 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.

Marketing Information

To the extent that I have opted in under step one of this form, I would like to receive information from Ipsen via mail, email, phone or SMS/text message, all of which may include telemarketing, 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. By signing below, I agree that Ipsen and its agents may use and disclose my personal information (including name, address, phone number, and/or email) to provide these services and Ipsen may also contact me to solicit my opinions regarding DYSPORT® and Ipsen's products and services. I understand that my cell phone carrier's standard rates may apply for calls 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 866-435-5677 or sending a request in writing to: IPSEN CARES®, 11800 Weston Parkway, Cary, NC 27513. 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.

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/.

Dysport®
(abobotulinumtoxinA)

IPSEN CARES® ENROLLMENT FORM

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

IPSEN CARES® Coverage, Access, Reimbursement & Education Support