The SOMATULINE DEPOT Patient Assistance Program (PAP) is designed to provide SOMATULINE DEPOT at no cost to eligible patients. Patients may be eligible to receive free drug if they are experiencing financial hardship, have no insurance coverage, and meet specific medical criteria as supported by information provided in the Program application. Eligibility does not guarantee approval for participation in the program. The SOMATULINE DEPOT PAP provides SOMATULINE DEPOT (lanreotide injection) product only, and does not cover the cost of previously purchased product or medical services.

Instructions: Both the patient and the healthcare provider have to complete the application.

PATIENT REQUIREMENTS
- Complete and sign the Patient Information section, including the Financial Information section.
- If you are seeking financial assistance from the PAP, please fax a copy of proof of total household income. Accepted forms include most recently filed Federal Tax Forms (i.e., Form 1040) including supporting documents (W-2), social security income (SSA 1099), or the completed Notarized Income Statement form included at the end of this application.

HEALTHCARE PROVIDER REQUIREMENTS
- Complete and sign the Healthcare Provider Information section.
- Verify that the patient is being prescribed and administered SOMATULINE DEPOT.
- Ensure the entire application is complete and signed before sending it to the fax number provided above.

It is important that you and your healthcare provider complete all requested information and sign where indicated. Since incomplete or incorrect applications will delay the application process, please ensure all information provided is correct.

We recommend that you fax the completed form in order to expedite the process. Once the application is received, we will evaluate the patient’s eligibility to participate in the SOMATULINE DEPOT PAP. Healthcare providers will be notified upon completion of eligibility review. Please note that program rules are subject to change without notice. For further assistance, please call (866) 435-5677 from 8:00 AM to 8:00 PM Eastern Time, Monday through Friday.

Please see SOMATULINE DEPOT full Prescribing Information at www.somatulinedepot.com.

Sincerely,

The IPSEN Coverage, Access, Reimbursement & Education Support (CARES) program
PATIENT INFORMATION: THIS SECTION TO BE COMPLETED BY THE PATIENT

First Name ___________________________________________ MI __________________________ Last Name __________________________

Date of birth (MM/DD/YYYY) / / 

Mailing Address ___________________________________________ Apt # __________________________

City __________________________ State __________ Zip __________

Social Security Number __________________________ Gender ☐ Male ☐ Female

Daytime Phone Number (____) __________ Evening Phone Number (____) __________

Email Address __________________________

Prescribing Physician __________________________ Treating Facility __________________________

ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

My estimated annual household income currently is $ __________________________

(Please include dollar amount of monthly income from)

$ Social Security Disability Income (SSDI) (beginning ______ / ______)

$ Supplemental Security Income (SSI)

$ Aid from the Department of Public Welfare

$ Unemployment Benefits (from ______ to ______)

$ Worker Compensation Benefits (from ______ to ______)

$ Dividends, interest, or investment accounts

$ Employment (myself and/or my spouse)

$ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household __________________________

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Status</th>
<th>Effective Date</th>
<th>Please indicate Primary(P) or Secondary(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>☐ Approved ☐ Denied ☐ Waiting for Decision</td>
<td>/ / /</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>☐ Approved ☐ Denied ☐ Waiting for Decision</td>
<td>/ / /</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>☐ Approved ☐ Denied ☐ Waiting for Decision</td>
<td>/ / /</td>
<td></td>
</tr>
<tr>
<td>TriCare</td>
<td>☐ Approved ☐ Denied ☐ Waiting for Decision</td>
<td>/ / /</td>
<td></td>
</tr>
<tr>
<td>Healthcare Exchange</td>
<td>☐ Approved ☐ Denied ☐ Waiting for Decision</td>
<td>/ / /</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>☐ Approved ☐ Denied ☐ Waiting for Decision</td>
<td>/ / /</td>
<td></td>
</tr>
<tr>
<td>☐ Uninsured</td>
<td>Patient is not eligible for any public health insurance, which includes Medicare and Medicaid, or has been denied coverage by a third-party payer.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health ("Health Information") to Ipsen Biopharmaceuticals, Inc. ("Ipsen") and the SOMATULINE® DEPOT Patient Assistance Program (the "PAP"). I know that the information I provide will be used by the PAP to decide if I am eligible for assistance, operate the PAP, send me information about the PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance, and/or medical information, and share my information as required or permitted by law. I give permission to the PAP to use information on this Application and any other information I give to the PAP for these same reasons. I also give Ipsen permission to share my Health Information and other information with people and companies that work with the PAP; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people, or institutions who are involved in my healthcare, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information, that I provide to PAP are complete and true, and unless I have said something different in this application, I have no drug insurance coverage, which includes Medicaid, Medicare, 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. All information that I provide may be used by Ipsen, or any third party working on behalf of Ipsen, in connection with the PAP. Ipsen and its third-party partners will keep my information confidential in accordance with all applicable US laws, rules, and regulations.

Patient Signature __________________________ Date __________

HEALTHCARE PROVIDER INFORMATION: THIS SECTION MUST BE COMPLETED BY THE PRESCRIBING PHYSICIAN

Prescriber Name __________________________ Street Address __________________________

DEA# __________________________ State license # __________________________

Tax ID # __________________________ NPI# __________________________

Medicaid provider # __________________________ Office contact and title __________________________

Medicare PTAN # __________________________ Phone (___) __________________________ Fax (___) __________________________

Office/Institution __________________________ Email Address __________________________

Specialty ☐ Endocrinologist ☐ Other __________________________ Preferred method of contact ☐ Phone ☐ Fax ☐ Email __________________________

PRESCRIBER ATTESTATION I certify that any medications received from Ipsen (as defined above) in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

Prescriber Signature __________________________ Date __________
INCOME REQUIREMENTS Use this form only if you cannot provide proof of income documentation.

My estimated annual household income currently is $ _____________________________

(please include dollar amount of monthly income from)

$ _____________________________ Social Security Disability Income (SSDI) (beginning _______/_____/______)

$ _____________________________ Supplemental Security Income (SSI)

$ _____________________________ Aid from the Department of Public Welfare

$ _____________________________ Unemployment Benefits (from _______/_____/______ to _______/_____/______)

$ _____________________________ Workers Compensation Benefits (from _______/_____/______ to _______/_____/______)

$ _____________________________ Dividends, interest, or investment accounts

$ _____________________________ Employment (myself and/or my spouse)

$ _____________________________ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household _____________________________

Patient Signature _____________________________ Date _____________________________

THIS FORM MUST BE NOTARIZED IN ORDER TO PROCESS YOUR APPLICATION.

State of _____________________________ County of _____________________________

___________________________ sworn and subscribed to me on this _______/_____/______ as to the completeness and truthfulness of the information contained herein.

(Patient Name)

Signature of Notary _____________________________

My commission expires _____________________________

NOTARY SEAL