Somatuline® Depot
(lanreotide) Injection

Please fill out form completely and
FAX BACK TO 866.435.4471

Please fax the signed form to PACE at the number above or send the form to:

PACE Program
Ipsen Biopharmaceuticals, Inc.
1011 Warrenville Road, Suite 115
Lisle, IL 60532

Patient Authorization

Patient Authorization and Signature—PACE Program

I authorize my doctor and his/her staff, my health insurer and/or specialty pharmacy to disclose personal health information (PHI) to Ipsen, its affiliates, and its agents who have been hired to administer the PACE program. I understand these parties will use and/or disclose my PHI, as needed, to coordinate the receipt, payment, and proper administration of Somatuline® Depot (lanreotide) Injection as prescribed by my doctor. I also authorize Ipsen to use and disclose PHI it receives about me to a pharmacy or distributor that will fill my prescription and to Ipsen's agents that implement disease management programs. I understand that once my PHI is disclosed, it may no longer be protected by federal law regarding patient privacy but that PACE will protect my information and use it only for the purposes of administering the PACE program. I understand that Ipsen may also contact me to solicit my opinions about PACE services. I understand that I do not have to sign this form and that I may revoke this authorization at any time. My refusal to sign this authorization or a future revocation will not affect the treatment I receive from my doctor; however, PACE may not be able to provide reimbursement assistance or find out if I am eligible for any other PACE services. This authorization is valid until December 31, 2020. To revoke this authorization, please call 866.435.5677 or send your request in writing to: PACE, 1011 Warrenville Road, Suite 115, Lisle, IL 60532.

I acknowledge that I would like to participate in the PACE program. I understand that by enrolling in the program, a Patient Care Liaison at PACE will contact me directly by phone or email.

Patient Name: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Signature _____ Date _____

Additional Product and Support Information

☐ In addition to participating in the PACE program above, I would also like to receive additional information from Ipsen, which may include receiving marketing and educational information about Somatuline Depot and programs that support patients with acromegaly. I understand that I do not have to sign this section of the form in order to participate in the PACE program and that I may revoke my 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 to provide these services and Ipsen may also contact me to solicit my opinions regarding Somatuline Depot, 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 is valid until December 31, 2020. To revoke this authorization, please call 866.435.5677 or send your request in writing to: Somatuline Depot Patient Marketing Programs, 1011 Warrenville Road, Suite 115, Lisle, IL 60532.

Patient Name: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Signature _____ Date _____

pace℠
Patient Access, Care & Education

Somatuline® Depot (lanreotide) Injection PACE Enrollment Form

Somatuline® Depot (lanreotide) Injection

Statement of Medical Necessity

Please fill out form completely and **FAX BACK TO 866.435.4471**

☐ All PACE Program Services ☐ Injection Training Only ☐ Benefits Investigation Only

PATIENT

Patient name (first & last) _____

Patient address _____

City _____ State _____ Zip _____

Date of birth (MM/DD/YY) _____ /_____/_____ ☐ Male ☐ Female

Email address _____

Home phone (_____) _____ Other phone (_____) _____

INSURANCE

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

Is patient insured? ☐ Yes ☐ No Does patient have secondary insurance? ☐ Yes ☐ No

Primary insurance co. _____

Insurance co. phone # _____

Subscriber _____

Policy/Employer/Group # _____

Subscriber ID/Policy # _____

Secondary insurance _____

Insurance co. phone # _____

DIAGNOSIS

Have you documented that your patient has experienced an inadequate response to or cannot be treated with surgery and/or radiotherapy? ☐ Yes ☐ No

Based on my evaluation, this patient's diagnosis is acromegaly (ICD-9 code 253.0):

☐ Yes ☐ If no, please provide the other diagnosis _____

Date of acromegaly diagnosis _____ /_____ /_____

Have other products been used to treat acromegaly for this patient? ☐ Yes ☐ No

Product _____ Date of last injection _____ /_____ /_____

SOMATULINE® DEPOT (lanreotide) Injection is a somatostatin analog indicated for the long-term treatment of patients with acromegaly who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy.

PRESCRIBER

Prescriber name _____

DEA # _____ St lic # _____

Tax ID # _____ NPI # _____

Medicaid provider # _____

Medicare PT AN # _____

Office/Institution _____

Specialty: ☐ Endocrinologist ☐ Other _____

Street address _____

City _____ State _____ Zip _____

Office contact and title _____

Phone (_____) _____ Fax (_____) _____

Email address _____

Preferred method of contact: ☐ Phone ☐ Fax ☐ Email

PRESCRIPTION AND PATIENT SUPPORT

Would you like us to provide starter therapy if patient is eligible? ☐ Yes ☐ No

Would you like to request injection training and nursing support through the Ipsen Nurse Network? ☐ Yes ☐ No

Ipsen nurse preference _____ ☐ No preference

If Yes, requested location for training is: ☐ Prescriber's office ☐ Patient's home/work

☐ Other MD office/clinic _____

Somatuline Depot injections will be given at:

☐ Prescriber's office ☐ Patient's home/work

Prescription: Somatuline® Depot (lanreotide) Injection

Strength: ☐ 60 mg (initial dose for renal and hepatic impaired patients)
☐ 90 mg (recommended starting dose) ☐ 120 mg (titration and EDI)

Route: Deep subcutaneous

Site of injection:

☐ Upper outer buttocks ☐ Rotate between both sites ☐ Other _____

Frequency: ☐ Every 28 days ☐ Other _____

Additional instructions _____

☐ Dispense as written Quantity _____ Number of refills _____

Send shipment to: ☐ Physician's office ☐ Patient's home

Special shipping instructions _____

Preferred specialty pharmacy _____

PRESCRIBER ATTESTATION:

By signing below, I certify that the above therapy is medically necessary and that I have received the necessary authorization to release the above referenced information and medical and/or patient information relating to Somatuline Depot therapy to Ipsen and its agents or contractors for the purpose of seeking reimbursement for Somatuline Depot therapy, assisting in initiating or continuing Somatuline Depot therapy, and/or evaluating the patient's eligibility for Ipsen's patient support programs administered by PACE. I authorize Ipsen to be my agent, to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen on behalf of the named patient.

_____
Prescriber Signature

_____
Date

QUESTIONS? CALL PACE AT 866.435.5677

Important Information About Somatuline® Depot (lanreotide) Injection

Before each treatment of Somatuline® Depot (lanreotide) Injection, please read the Patient Information that comes with each package as there may be new information. Talk with your doctor about your medical condition or your treatment. Your doctor is your primary source of information about treatment.

What is Somatuline Depot?

Somatuline Depot is a prescription medicine used for the long-term treatment of acromegaly when surgery or radiotherapy has not worked well enough or the patient is not able to have surgery or radiotherapy.

It is not known if Somatuline Depot is safe and effective in children.

Before you receive Somatuline Depot, talk to your doctor about:

All of your medical conditions, including

- Gallbladder, thyroid, heart, kidney, or liver problems
- Diabetes
- Allergy to latex or natural dry rubber
- Pregnancy or plans to become pregnant
  - It is not known if Somatuline Depot could harm your unborn baby
- Breast-feeding or plans to breast-feed
  - It is not known if Somatuline Depot passes into breast milk

Any medicines (prescription and nonprescription) you are taking, including

- Insulin or other diabetes medicines
- A cyclosporine (such as Gengraf, Neoral, or Sandimmune)
- A medicine called bromocriptine (such as Parlodel)
- Medicines that lower your heart rate (such as beta blockers)

What are the possible side effects of Somatuline Depot?

Somatuline Depot may cause serious side effects, including

- **Gallstones.** Tell your doctor if you have sudden pain in your upper right stomach (abdominal) area or in your right shoulder or between your shoulder blades, or if you have yellowing of your skin and whites of your eyes, fever with chills, or nausea
- **Changes in your blood sugar (high blood sugar or low blood sugar).** If you have diabetes, test your blood sugar as your doctor tells you to. Your doctor may change your dose of diabetes medicine especially when you first start receiving Somatuline Depot or if your dose of Somatuline Depot changes
- **Slow heart rate**
- **High blood pressure**

The most common side effects of Somatuline Depot include diarrhea, stomach area (abdominal) pain, nausea, and pain, itching, or a lump at the injection site.

These are not all the possible side effects of Somatuline Depot. Tell your doctor if you have any side effect that bothers you or that does not go away.

You may report side effects to FDA at 1-800-FDA-1088.

Indication

Somatuline® Depot (lanreotide) Injection is indicated for the long-term treatment of acromegalic patients who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy.

Important Safety Information

Warnings and Precautions:

- Somatuline may reduce gallbladder motility and lead to gallstone formation. Periodic monitoring may be needed.
- Patients may experience hypoglycemia or hyperglycemia. Glucose level monitoring is recommended and antidiabetic treatment adjusted accordingly.
- Somatuline may decrease heart rate. In cardiac studies, the most common cardiac adverse reactions were sinus bradycardia, bradycardia, and hypertension. Dose adjustment of coadministered drugs that decrease heart rate may be necessary.
- Somatuline may decrease bioavailability of cyclosporine. Cyclosporine dose may need to be adjusted.

Adverse Reactions:

The most common adverse reactions (incidence >5%) were diarrhea (37%), cholelithiasis (20%), abdominal pain (19%), nausea (11%), injection-site reaction (9%), constipation (8%), flatulence (7%), headache (7%), arthralgia (7%), vomiting (7%), and loose stools (6%).

Use in Special Populations:

Patients with moderate and severe renal impairment or moderate and severe hepatic impairment: Initial dose is 60 mg every 4 weeks.