Medical Information Request Form

For Use with US Health Care Professionals Only

Date: ______________________ **Ipsen Employee:** ______________________________

Phone: ____________________________ **E-mail:** ______________________________

To ensure a prompt response, please fully complete this form, including HCP signature

Name:____

☐ M.D. ☐ D.O. ☐ Pharm.D. ☐ R.Ph. ☐ R.N. ☐ Other__________

HCP specialty: ☐ Endocrinology ☐ Oncology ☐ Neurology ☐ Other:___________

Institution/Office: ____

Address: ____

City:______________________________State: ______________ Zip:________________

Phone:________________Fax:_________________E-mail: _____________________

Please select one:

☐ Dysport® (abobotulinumtoxinA)

☐ Increlex® (mecasermin [rDNA origin])

☐ Onivyde® (irinotecan liposome injection)

☐ Other: ____________________

☐ Somatuline® Depot (lanreotide)

Question or Information Requested:

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Preferred written response method:	☐ US Mail ☐ Fax ☐ Email (please provide email address above) ☐ Hard copy provided by Ipsen directly to HCP
Request contact by:	**Medical Science Liaison (MSL):** ☐ Yes ☐ No **Health Economics & Outcomes Research (HEOR) Liaison** ☐ Yes ☐ No

Signature of US Health Care Professional: ____

(By signing this form, I certify that I initiated the above request for information and this request was not solicited by an Ipsen employee.)

To contact the Ipsen Medical Information Department:

Scan & email to:	Fax to:	Phone:
medinfo.usa@ipsen.com	**(866) 681-1063**	**(855) 463-5127**

The information that you have provided will be treated in accordance with Ipsen's Privacy Policy, which can be accessed at www.ipsenus.com.

NON-US-000475

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