



## BOTOX PATIENT ASSISTANCE<sup>®</sup> Program Application Instruction Letter

Thank you for your interest in the BOTOX PATIENT ASSISTANCE<sup>®</sup> Program for uninsured and underinsured patients who have insufficient resources to pay for their medication. To assist these patients, Allergan, Inc. is donating BOTOX<sup>®</sup> vials for qualifying patients at no charge. Cash payments are not involved.

Please complete the application for provider sponsorship and patient enrollment. In addition, please note that the provider and patient must complete the following important steps:

1. The provider sponsor must sign the Certification and Consent Statement on the completed application form.
2. The patient must sign the Certification and Consent Statement on the completed application form.
3. The patient must submit an acceptable form of the patient's (or guardian's) income documentation.

Acceptable forms of income documentation include one of the following:

- 1040, 1040A or 1099 from the most recent tax year
- W-2
- Social Security Statement

Please remember that patients are not eligible for consideration to participate in the BOTOX PATIENT ASSISTANCE<sup>®</sup> Program until we receive the necessary form and income documentation.

Once the completed application is signed and the income documentation is collected, please mail or fax them to the BOTOX PATIENT ASSISTANCE<sup>®</sup> Program. If you have any questions or need personal assistance, please call us at 1-800-44-BOTOX (Option 4) between 9:00AM and 8:00PM EST.

Thank you for helping your financially needy patients gain access to BOTOX<sup>®</sup> by participating as a provider sponsor.

Sincerely,

The BOTOX PATIENT ASSISTANCE<sup>®</sup> Program

**BOTOX PATIENT ASSISTANCE<sup>®</sup> Program**

PO Box 1370 • San Bruno, CA 94066 • Phone: 800-44-BOTOX (Option 4) • Fax: (877) 530-6680

Allergan reserves the right to modify or discontinue the BOTOX PATIENT ASSISTANCE<sup>®</sup> Program at any time, without further notice.



# BOTOX PATIENT ASSISTANCE<sup>®</sup> Program Application Form

Date: \_\_\_\_\_

## PROVIDER SPONSOR INFORMATION

Provider Sponsor Name: _____	Contact Person and Title: _____
Address: _____	City: _____ State: _____ Zip: _____
Phone Number: _____	Fax Number: _____
Facility Name: _____	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other
License Number: _____	NPI: _____

Please provide contact person and address for product shipment (if different from above):

Provider Sponsor Name: _____	Contact Person and Title: _____
Address: _____	City: _____ State: _____ Zip: _____
Phone Number: (    ) _____	Fax Number: (    ) _____

## TREATMENT INFORMATION

Diagnosis (ICD-9 Code): _____	Estimated Dose (in 100 Unit vials): _____
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I certify that I have read the Sponsor Certification and Consent Statement in full and that I understand and agree to the terms stated in the Declaration by signing below.

_____ Provider Sponsor's Signature (required)	_____ Date Signed (required)
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## PATIENT INFORMATION

Patient Full Name: _____	Social Security Number: _____
Address: _____	City: _____ State: _____ Zip: _____
Phone Number: _____	Date of Birth: _____
Number of members in household: _____	U.S. Resident (including Puerto Rico and U.S. Territories): <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient's annual gross household income: \$ _____	Income Source: <input type="checkbox"/> 1040 <input type="checkbox"/> 1040A <input type="checkbox"/> 1099 <input type="checkbox"/> W-2 <input type="checkbox"/> Social Security Statement

I certify that I have read the Patient Certification and Consent Statement in full and that I understand and agree to the terms stated in the Declaration by signing below.

_____ Patient's Signature (required)	_____ Date Signed (required)
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Please provide documentation verifying your income by attaching a copy of your 1040, 1040A, or 1099 from the most recent tax year, W-2, or Social Security Statement.

## INSURANCE INFORMATION

<input type="checkbox"/> HMO/EPO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance	
Primary Insurance Company: _____	Secondary Insurance Company: _____
Policy Number: _____ Group Number: _____	Policy Number: _____ Group Number: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone Number: _____	Phone Number: _____
Subscriber's Name _____ Date of Birth: _____	Subscriber's Name _____ Date of Birth: _____
Subscriber's Relationship to Patient: _____	Subscriber's Relationship to Patient: _____

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**PLEASE READ DECLARATION BEFORE SIGNING FRONT OF FORM**

**PROVIDER SPONSOR CERTIFICATION AND CONSENT STATEMENT**

The BOTOX PATIENT ASSISTANCE® Program offers assistance to financially eligible patients who need BOTOX® treatment. Patients who are uninsured or underinsured and are unable to afford the cost of therapy may be eligible for enrollment. While Allergan makes every effort to grant aid when needed and appropriate, the program is limited in available resources and may be discontinued at any time, without further notice.

I certify that the use of BOTOX® is medically necessary and appropriate and that I will be supervising the patient's treatment accordingly.

I further certify that, to the best of my knowledge, this patient has no medical insurance coverage for BOTOX®, including Medicaid/Medicare or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I agree not to bill or collect from the patient or any government or private payer, or to trade, sell, barter for or return for credit any BOTOX® provided under the BOTOX PATIENT ASSISTANCE® Program.

I also certify that my patient understands that these costs are his/her responsibility if I am unable to waive the administration fee.

I agree that any BOTOX® I receive for the patient named in the application will be used only for this patient.

I also understand that Allergan Inc. reserves the right to modify or discontinue the BOTOX PATIENT ASSISTANCE® Program at any time, without further notice.

**PATIENT CERTIFICATION AND CONSENT STATEMENT**

Under this program, Allergan agrees to ship product to the sponsor for vials of therapeutic BOTOX® for patients who have met the requirements set forth by the BOTOX PATIENT ASSISTANCE® Program. All of the terms and conditions below must be met in order for a patient to be enrolled in the program.

- Patient must meet the eligibility criteria
- Sponsor must complete and sign the application.
- Patient must complete and sign the application and provide income documentation

I understand that this patient assistance program provides BOTOX® at no charge and does not include the provider administration fee.

I verify that the information provided in this application is complete and accurate to the best of my knowledge and may be used by Allergan Inc. and/or its agent or authorized designee in determining eligibility to participate in the BOTOX PATIENT ASSISTANCE® Program I understand that at such time as I obtain coverage or have the financial resources to pay for the cost of therapeutic BOTOX®, I will notify Allergan of such a change in my coverage status. I understand that I will be re-evaluated for eligibility for the BOTOX PATIENT ASSISTANCE® Program every 12 months.

I understand that, by my signature, any and all information that I provide may be shared with my treating provider.

By my signature, I agree that Allergan Inc. and/or its agent or authorized designee may contact my health care provider to request information concerning my medical condition and I hereby direct them to provide information relative to my medical condition or treatment of drug therapy, as requested. In addition, I agree that Allergan Inc. and/or its agent or authorized designee may contact my payer to obtain benefit information for therapeutic BOTOX®.

Allergan Inc. and/or its agent or authorized designee agrees not to disclose any information obtained from these sources to any third party except as provided herein or except as required by applicable law.

I also understand that Allergan Inc. reserves the right to modify or discontinue the BOTOX PATIENT ASSISTANCE® Program at any time, without further notice.

**ADDITIONAL BOTOX® INFORMATION**

- Yes, I am interested in receiving additional information about BOTOX®
- No, I am not interested in receiving additional information about BOTOX®

\_\_\_\_\_  
Patient's Signature (required)

\_\_\_\_\_  
Date Signed (required)

® mark owned by Allergan, Inc.

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## HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF PATIENT INFORMATION

I authorize my physician, \_\_\_\_\_ (“Physician”) to give Allergan, Inc., any subcontractors or agents of Allergan, Inc. (“Allergan”) information about me which is necessary to determine my eligibility for the BOTOX PATIENT ASSISTANT Program (“Program”), to administer the Program and to account for my withdrawal should I decide to stop participating in the Program. I understand that the type of information that can be given under this authorization may include my name, birth date, address, telephone number, social security number, income, prescription coverage, prescription for medication(s), financial documents and insurance records. I further understand that if my information is incomplete or the completed information does not allow me to participate in the Program that I may be notified of such by Allergan. I also understand that signing this authorization does not guarantee that I will be accepted into the Program. I further understand that because Allergan is not covered by federal privacy regulations, after my information is disclosed to Allergan, it will no longer be protected under federal law and could be subject to re-disclosure. This authorization will expire one (1) year after the date it is signed below, or one (1) year after the last date I receive medications under the Program, whichever is later. I may cancel this authorization at any time by providing written notice to Allergan at the address set forth below. My revocation will become effective on the date my written notice is received and processed by the Program and at such time I will no longer be qualified to receive medication assistance from the Program. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment from my Physician, but that I will not be able to participate in the Program.

You are entitled to a copy of this authorization for your records.

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Signature of patient or authorized person

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Date

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Relationship/Reason patient is unable to sign