AMYLIN PHARMACEUTICALS, INC.
PATIENT ASSISTANCE APPLICATION

Phone Toll Free: 1-800-330-7647

____**BYETTA® (exenatide) injection** ☐ **New Application** ☐ **Renewal**

Patient Information:

☐Mr. ☐Mrs. ☐Ms. Patient Name_____

Mailing Address_____

City_____ State_____ Zip Code_____

Day Phone_____Evening Phone_____

Date of Birth_____ Social Security #_____

Do you have Type 2 Diabetes? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Are you a U.S. citizen? ☐ Yes ☐ No **(If no, please provide proof of US residency, such as copy of your Driver's License, Green Card or other government-issued ID that identifies your address)**

Are you employed? ☐ Yes (☐ Full-time or ☐ Part-time) ☐ No ☐ Self-employed
Employer Name _____

Employer Address _____

Household Size (number of persons dependent upon total household income): _____

Physician Information:

Physician Name_____

Address_____

City _____ State _____ Zip Code_____

Phone _____ Fax _____

Insurance Information:

Are you a participant in any of the following? (Check all that apply):

☐ Medicare Part A
☐ Medicare Part B
☐ Medicare Part C (Medicare Advantage)
☐ Medicare Part D (Medicare prescription drug plan)
☐ Medicaid
☐ TriCare/CHAMPUS
☐ Veterans Administration
☐ Indian Health Services
☐ Public Health Service
☐ Any other Federal or State healthcare program, please list _____

_____

Do you have private health insurance? ☐ Yes ☐ No

If yes, name of Primary Insurer: _____

ID # _____ Phone _____

Name of Secondary Insurer: _____

ID # _____ Phone _____

Have you applied for Medicaid? ☐ Yes ☐ No

If yes, date you applied _____ Were you approved? ☐ Yes ☐ No

Financial Information (Documentation of income required):
Household Income:
Please identify your household's Adjusted Gross Income as it appeared on the most recent year's federal tax return (IRS Form 1040): $_____.

Please attach a COPY of:
1 - A prescription for BYETTA signed by your physician (do not send the original)

2 - The most recent year's federal tax return (IRS Form 1040) *as well as* the W2 forms and any other supporting documentation of your household income (schedule C, E, 1099 etc.). The AMYLIN Patient Assistance Application cannot be processed without this documentation.

- **In the event that you did not file a federal tax return last year, please provide a detailed statement of your annual household income.**
- **Please note that household income includes any social security and/or disability payments you receive.**

Patient Certification, Disclaimer, and Waiver

By signing below I attest and verify that all insurance and income information provided on this application, as well as all supporting documentation I have provided, is complete and accurate. I consent to have AMYLIN or its agents audit or otherwise verify the information I have provided to determine my eligibility for the Patient Assistance Program (PAP). I consent to the release of confidential information, including the information on this form, by my physician for the purposes of determining eligibility under the PAP. I authorize the assigned Reimbursement Specialist to contact the insurance companies listed on this form as well as other potential city, state, county or federal funding sources, social worker or patient advocacy organization to determine my eligibility for alternate health insurance coverage/funding.

Patient Signature *(an original signature is required):* _____

Date: _____

Patient Guardian Signature *(If applicant is under 18)*
Or other authorized person *(specify relationship):* _____

Relationship: _____Date: _____

Please return completed application form and required documentation to:
AMYLIN PATIENT ASSISTANCE PROGRAM
PO Box 8435
Gaithersburg, MD 20898-8435

Disclaimer: The criteria for the Amylin Patient Assistance Program for Byetta are subject to change without notice at the discretion of the manufacturer.

Amylin Patient Assistance Program Checklist

Please review carefully: If you provide incorrect or incomplete information, it will delay the review of your application. Before mailing your application to the Assistance Program Administrator, be sure you have completed the following:

☐ **Sign and date the application**

☐ **Complete the application in its entirety including:**

- ✓ All insurance information (if applicable)
- ✓ This includes ***Medicare*** and ***Medicaid***
- ✓ Policy name (Example: BCBS ID number) and telephone number for Health Plan.
- ✓ Prescribing physician's name, address, and telephone number
- ✓ Required information if not a U.S. citizen (Example: copy of Driver's License, Green Card, or other government issued ID)
- ✓ Household income (total income from all individuals, including social security, pension, Schedule C if self employed, and 1099 forms).
- ✓ Household Size

☐ **Provide correct documentation of income**

Required documents:

- ✓ **Employed:** 1040* and W-2's for each member of the household
- ✓ **Self-Employed:**1040* and Schedule C (W-2's if other members of the household are employed)

*In the event you do file taxes please submit all documents that support your 1040. These documents may include: Schedules D, E and/or F, Form 4797, 1099 (Social Security Benefits, Disability Benefits, IRA Distributions, and Pension and Annuity Statements) and Unemployment Compensation Statement. Please note that financial documentation is required for each household member that contributes to the household income.

- ✓ **In the event you do not file taxes please submit a detailed statement of your annual household income. Please note that if you receive Social Security benefits, IRA distributions, disabilities, pension and annuities please include as part of your household income.**

☐ **Medical Documentation:**

- ✓ Copy of Prescription

Please allow two to three weeks for the processing of your application. Should we need additional information, you will be contacted by mail.