

# AMYLIN PHARMACEUTICALS, INC. PATIENT ASSISTANCE APPLICATION

1-800-330-7647 (Toll Free) - 1-800-330-7718 (Toll-Free Fax)

**Medication Name:**  BYETTA® (exenatide) injection  SYMLIN® (pramlintide acetate) injection

(Please check one)

## Patient Information

Mr.  Mrs.  Ms. Patient Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_ Pharmacy Fax \_\_\_\_\_

Do you take insulin for control of your diabetes?  Yes  No

What type of diabetes do you have?

Type 1 Diabetes

Type 2 Diabetes

Marital Status:  Single  Married  Divorced  Separated  Widowed

Are you a U.S. citizen?  Yes  No (If YES, please provide proof of US legal residency, such as copy of your valid, unexpired US passport, Certificate of Citizenship, or Certificate of Naturalization that identifies you and your address ; if NO, please provide your Permanent Resident Card, Employment Authorization Document, or Social Security Card)

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):

Did you file a federal tax return?  Yes  No

If no, were you claimed as a dependent on another person's return?  Yes  No

**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 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 my confidential information, including the information on this form, both to my physician from a Reimbursement Specialist and 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 Name** (print): \_\_\_\_\_

**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 is subject to change without notice at the discretion of the manufacturer.**

For important information about the risk of severe low blood sugar, please read the Important Patient Safety Information and the SYMLIN Medication Guide at [www.SYMLIN.com](http://www.SYMLIN.com).

## 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 residency information (Example: **for U.S citizen:** copy of valid, unexpired US passport, Certificate of Citizenship, or Certificate of Naturalization; **for non U.S citizen:** Permanent Resident Card, Employment Authorization Document, Social Security Card)
- ✓ 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-2s for each member of the household
- ✓ **Self-Employed:** 1040\* and Schedule C (W-2s 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 e-mail, phone, and/or mail.