



BOTOX PATIENT ASSISTANCE[®] Program Application Instruction Letter

Thank you for your interest in the BOTOX PATIENT ASSISTANCE[®] Program for uninsured and underinsured patients who have insufficient resources to pay for their medication. To assist these patients, Allergan, Inc. is donating BOTOX[®] 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[®] 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[®] Program. If you have any questions or need personal assistance, please call us at 1-800-44-BOTOX (Option 6) between 9:00AM and 8:00PM EST.

Thank you for helping your financially needy patients gain access to BOTOX[®] by participating as a provider sponsor.

Sincerely,

The BOTOX PATIENT ASSISTANCE[®] Program

BOTOX PATIENT ASSISTANCE[®] Program

PO Box 1370 • San Bruno, CA 94066 • Phone: 800-44-BOTOX (Option 6) • Fax: (877) 530-6680

Allergan reserves the right to modify or discontinue the BOTOX PATIENT ASSISTANCE[®] Program at any time, without further notice.



BOTOX PATIENT ASSISTANCE® Program Application Form

Date: _____

PROVIDER SPONSOR INFORMATION

Provider Sponsor Name: _____

Address: _____

Phone Number: _____

Facility Name: Physician's Office Hospital Other

Contact Person and Title: _____

City: _____

State: _____

Zip: _____

Fax Number: _____

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

Provider Sponsor Name: _____

Address: _____

Phone Number: _____

Contact Person and Title: _____

City: _____

State: _____

Zip: _____

Fax Number: _____

TREATMENT INFORMATION

Diagnosis (ICD-9 code): _____

Estimated Dose (in vials): _____

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)

PATIENT INFORMATION

Patient Full Name: _____

Address: _____

Phone Number: _____

Number of members in household: _____

Patient's annual gross household Income: \$ _____

Social Security Number: _____

City: _____

State: _____

Zip: _____

Date of Birth: _____

U.S. Resident (including Puerto Rico and U.S. Territories): Yes No

Income Source: 1040 1040A 1099 W-2 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)

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 VERIFICATION

HMO/EPO PPO POS Indemnity Medicare Medicaid No Insurance

Primary Insurance Company: _____

Policy Number: _____

Group Number: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____

Subscriber's Name: _____

Date of Birth: _____

Subscriber's Relationship to Patient: _____

Secondary Insurance Company: _____

Policy Number: _____

Group Number: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____

Subscriber's Name: _____

Date of Birth: _____

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 for BOTOX®.

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

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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