Lilly Cares Foundation Patient Assistance Program
PO Box 13185
La Jolla, CA 92039
Phone: 1-800-545-6962 Fax: 1-844-431-6650
www.lillycares.com

Application Form Instructions

The Lilly Cares Foundation, Inc. ("Lilly Cares"), a nonprofit organization, offers a patient assistance program to assist qualifying patients in obtaining certain Lilly medications at no cost.

Please complete and submit by fax or mail, or you may choose to apply online at www.lillycares.com.

What medications are included?

Group 1 Medications: For patients who have no insurance or have Medicare Part D and have a household annual adjusted gross income ≤ 300% Federal Poverty Level (FPL).

- Cialis® (tadalafil)
- Cymbalta® (duloxetine delayed-release capsules)
- Evista® (raloxifene hydrochloride)
- Forteo® (teriparatide [rDNA origin] injection)
- Prozac® (fluoxetine)
- Strattera® (atomoxetine)
- Symbyax® (olanzapine and fluoxetine)
- Zyprexa® (olanzapine)

Group 2 Medications: For patients who have no insurance or have Medicare Part D and have a household annual adjusted gross income ≤ 400% FPL.

- Basaglar® (insulin glargine injection)
- Emgality™ (galcanezumab-gnlm) injection
- Glucagon (glucagon for injection [rDNA origin])
- Humalog® (insulin lispro injection)
- Humulin® (human insulin [rDNA origin])
- Trulicity® (dulaglutide)

Group 3 Medications: For patients who have no insurance or have Medicare Part D or, in some circumstances, those whose insurance does not cover the prescribed Lilly medication and have a household annual adjusted gross income ≤ 500% FPL.

- Humatrope® (somatropin) for injection
- Olumiant® (baricitinib) tablets
- Taltz® (ixekizumab) injection

Patients may apply to Lilly Cares to receive prescribed Lilly oncology medications by completing a separate application available by calling 1-800-545-6962 or visiting the resources tab of www.lillycares.com.

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Who qualifies for Lilly Cares?

To qualify, you must meet ALL of the requirements listed below:

- My healthcare provider has prescribed a Lilly medication listed above.
- I am a permanent, legal resident of the United States or Puerto Rico.
- I am not enrolled in Medicaid, full Low Income Subsidy (LIS, “Extra Help”) or Veterans (VA) Benefits (Humatrope patients with VA and Medicaid benefits may be eligible).
- If I am a Medicare Part D patient, I have spent $1,100 on prescription medication this calendar year. This does not apply to Forteo, Humatrope, Olumiant, and Taltz patients.
- My annual household income is less than the Annual Adjusted Gross Income Limit listed below:

Total Number of Persons in your Household (including applicant)	Annual Adjusted Gross Income Limit* If you live in Alaska or Hawaii, please contact us for annual adjusted gross income limits		
	Group 1 Medications	**Group 2 Medications**	**Group 3 Medications**
1	$36,420	$48,560	$60,700
2	$49,380	$65,840	$82,300
3	$62,340	$83,120	$103,900
4	$75,300	$100,400	$125,500
5	$88,260	$117,680	$147,100
6	$101,220	$134,960	$168,700

**Note: These income limits are 300% (Group 1 Medications), 400% (Group 2 Medications), and 500% (Group 3 Medications) of 2018 Federal Poverty Guidelines. Visit www.aspe.hhs.gov/poverty for information on the Federal Poverty Level.*

How do I apply?

1. Review and complete the Patient Section (page 4-7); **sign** the Patient Certification on page 7.
2. Have your healthcare provider complete and **sign** the Healthcare Provider/Prescriber Section (page 8), **sign** the Healthcare Provider’s/Prescriber’s Confirmations and Agreements (page 9), and return along with a prescription for your medication.
3. Provide a copy of proof-of-income documents as noted on page 4. Keep original documents for your records. Your personal information, including Social Security Number, will also be used to obtain your credit information for purposes of confirming income.
4. Fax or mail the completed application, prescription, and copies of proof-of-income to Lilly Cares. The fax number and mailing address are at the top of page 1.
5. **Humatrope Patients** must submit a “no funding letter” from Humatrope DirectConnect which states they have no insurance benefits for their Humatrope therapy. Contact Humatrope DirectConnect at 1-844-862-8767 if you need this letter. A “no funding letter” is not required for Medicare Part D patients.

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What happens next?

When we receive your application, we will review it to see if you qualify for Lilly Cares.

- **If you qualify for Lilly Cares**:
  1. You and your healthcare provider will receive a letter notifying you of enrollment.
  2. You will be enrolled for 12 months. If you are a Medicare Part D patient, you will be enrolled through the end of the calendar year.
  3. You will pick up your medication from your healthcare provider in 10-14 business days. (Forteo, Humatrope, Olumiant, and Taltz generally require home delivery due to medication handling, and the patient will be contacted to schedule home delivery).
- **If you do not qualify for Lilly Cares, we will send a notice to you and your healthcare provider**.

If you have questions about qualifying and applying, please call Lilly Cares at 1-800-545-6962.

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Patient Section

All fields are required. Please print clearly.

Patient Name: (Last) ______________________________ (First) ___________________________ (MI) ________

Address: ____

City: ____ State: _______ Zip: ________________

Date of Birth: _____/_____/_____ Social Security Number (for income verification): _______-_______-_______
Month Day Year

Home Phone: (_______) _______ - ____________ Cell Phone: (_______) _______ - ____________

Patient Income Information

Number of persons living in your household, including applicant: ________

Total household annual (yearly) adjusted gross income: _______________________________

Proof of income—send copies only, no originals: Send at least 1 document that shows your income, such as last year's Federal Income Tax return, W2, or Social Security statement.

Additional proof of out-of-pocket pharmacy spend required for Medicare Part D patients (except Forteo, Humatrope, Olumiant, and Taltz patients): Send proof that you have spent $1,100 on prescriptions this calendar year. This can be an Explanation of Benefits (EOB) statement or summary from your pharmacy where you get your prescriptions filled.

Insurance Information

Do you have insurance? (check all that apply)	
Medicaid	Private/Commercial Insurance
Medicare Part D □ Full Low Income Subsidy (LIS/"Extra Help")	VA or Military
None	Other:

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Optional Text Message Notification of Approval

If your application is **approved**, we can send you a text message. The text message is optional. You can participate in Lilly Cares without signing up for the text message.

When you sign up for the text message, you must agree to the following conditions:

- Lilly Cares will send only one message. It will be an autodialed, pre-recorded text message. (Standard text message and data rates apply.)
- You can opt out at any time by calling 1-800-545-6962.
- Be aware that anyone who can open your phone might see your text message.
- The text message is NOT a reminder to take your medication. You are responsible to take your medication as prescribed.
- Do NOT report product complaints or adverse events (like side effects) by text message. To report these, please call The Lilly Answers Center at 1-800-LillyRX (1-800-545-5979).

To receive a text message, you must provide your cell phone number: ___________________________

Optional Authorization to Speak with Authorized Representative

If you would like to provide the name(s) of an individual(s) whom you authorize to speak with Lilly Cares on your behalf about this application or your participation in the Lilly Cares Program, please identify the individual(s) below.

An authorized representative has the authority to interact with Lilly Cares on an applicant's behalf with respect to the Lilly Cares application and program, and can provide or receive personal information about the applicant as necessary until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

By providing the name(s) below, I certify that individual(s) is aware and has consented to my disclosure of their name to Lilly Cares for the purpose of serving as my authorized representative.

1. Print Name of Authorized Representative: ____

2. Print Name of Authorized Representative: ____

You can remove Authorized Representative(s) at any time by calling 1-800-545-6962.

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Patient Certification (Agreement)

I certify (agree) that the following statements are true:

- I am a permanent, legal resident of the United States or Puerto Rico.
- My healthcare provider prescribed a Lilly medication in Group 1 or 2 and I have Medicare Part D or have no insurance.
- My healthcare provider prescribed a Lilly medication in Group 3 and I have Medicare Part D or have no insurance or, in some circumstances, my insurance does not cover the Lilly medication.
- I am not enrolled in Medicaid, full Low Income Subsidy (LIS, “Extra Help”) or Veterans (VA) Benefits (Humatrope patients with VA and Medicaid benefits may be eligible).
- If I am a Medicare Part D patient, I have spent $1,100 on prescription medication this calendar year. This does not apply to Forteo, Humatrope, Olumiant, and Taltz patients.

I consent to the sharing, use, and receipt of information about me, as described:

To run Lilly Cares, Lilly Cares needs some information about you. When you sign below, you are authorizing any pharmacy, healthcare provider, and or others who are in possession of your personal information, including health information, to share information about you with Lilly Cares, Eli Lilly & Company, and their affiliates, employees, agents, vendors, and business partners who may be assisting with the administration of Lilly Cares (“Receiving Entities”), including health information; in addition, you understand and are authorizing the Receiving Entities to share, use, and disclose your information for the purposes of operating the program.

The Receiving Entities may receive, share, and use the following information:

- Information in this application.
- Information about your medical conditions, treatment, current and future medications, and insurance information.
- Other information the Receiving Entities may obtain to operate Lilly Cares.
- The Receiving Entities may share your information with your healthcare providers and pharmacists.
- Your healthcare providers and pharmacists may share your information with the Receiving Entities.
- The Receiving Entities may share your information with the Centers for Medicare & Medicaid Services (CMS) and/or your Medicare Part D Plan Administrator. This will be consistent with the terms of any Data Sharing Agreement agreed upon by the Receiving Entities and CMS or your Medicare Part D Plan.

The Receiving Entities may share your information for the following purposes:

- To review your application and to contact you or your healthcare provider, if necessary, for that review.
- To help operate Lilly Cares and for the Receiving Entities’ internal purposes involving other patient assistance and charitable programs.
- To your pharmacies and healthcare providers relating to your participation in Lilly Cares, including personal information and information about your prescription medications.

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Patient Certification (Agreement)--Continued

By my signature below, I also agree to the following:

- If I am **NOT** a Medicare Part D participant, I understand that my authorization to release my Protected Health Information (PHI) enables a healthcare provider relying on this authorization to release my PHI to the Receiving Entities for one year from the date it is signed, and then I need to apply again to Lilly Cares.
- If I am a Medicare Part D participant, I understand that my authorization to release my PHI enables a healthcare provider relying on this authorization to release my PHI to the Receiving Entities for the remainder of this calendar year that it is signed, and then I need to apply again to Lilly Cares.
- I understand that if my information is shared in this manner, federal and state privacy laws may no longer protect my PHI and may not prohibit its further disclosure; however, the Receiving Entities have committed to use and disclose my PHI only as stated in this form.
- I authorize the Lilly Cares Program Representatives to obtain a consumer report about me in conjunction with my application. Lilly Cares may use my name, date of birth, address, and social security number to obtain my consumer report including, but not limited to, information regarding my household size and income. My consumer report will be used to estimate my household income as part of the process to decide if I am eligible to receive free medication from Lilly Cares. This soft credit inquiry will not impact my credit score. Upon request, Lilly Cares will provide me the name and address of the consumer reporting agency that provides the credit information. I may call Lilly Cares at 1-800-545-6962 for this information.
- I understand if I do not sign or refuse to sign this form, I will not be eligible for Lilly Cares.
- I understand that I can cancel my consent at any time by sending a written notice to Lilly Cares at the address on this application. If I cancel my consent, I will no longer qualify for Lilly Cares. My healthcare providers will no longer share my PHI with the Receiving Entities after the date that the Receiving Entities receive and process my cancellation letter, but this will not affect information or disclosures shared before that time. Additionally, once my cancellation is received and processed by the Receiving Entities, my participation in Lilly Cares will be terminated, and after my participation is terminated, the Receiving Entities will only maintain and use my information for legal and regulatory purposes.
- I agree to follow the rules and conditions of Lilly Cares.
- I have been provided a copy of this authorization.
- I understand that Lilly Cares will decide if I qualify for this program. I understand that my application might not be approved.
- I will not submit any claim for reimbursement to any third party insurer for any product provided to me under Lilly Cares.
- If I am in Medicare, I will not claim any true-out-of-pocket cost from my Medicare Part D Plan for the value of the product given to me under Lilly Cares.
- If I am in Medicare, I understand that it is my responsibility to let my Medicare Part D Plan know about my enrollment in Lilly Cares.
- I agree to notify Lilly Cares of changes to my income or insurance status that may impact my eligibility for Lilly Cares.
- I understand Lilly Cares may change or end at any time without advance notice.
- I understand and agree that if a Receiving Entity asks, I will provide documentation that proves the information I have certified in this application is true, correct, and complete.
- I understand that The Lilly Cares Foundation does not charge a fee for participation in Lilly Cares. The Lilly Cares Foundation is not affiliated with third parties who charge a fee for help with enrollment or medication refills. These third parties may reference Lilly Cares without permission of The Lilly Cares Foundation. I am not required to use a third party who charges a fee to help with my enrollment, and if I use a third party who charges a fee to help with my enrollment or refills of my medication, this money is not paid to the Lilly Cares Foundation.

Patient or Legal Guardian Signature: ______________________________ **Date:** ____________

Signature Required

Patient Printed Name: ____

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Healthcare Provider/Prescriber Section

Name of Lilly Cares applicant: ______________________________ Date of Birth: ____________
Please print name

Healthcare provider/prescriber: ______________________________ (circle: M.D. D.O. N.P. P.A., R. Ph., Other)
Please print name

Mailing address of healthcare provider: ____

City: ________________________ State: ________ Zip: ____________ Suite number: __________

(Note: Lilly Cares cannot ship to a P.O. Box. Lilly Cares medications are shipped to the healthcare provider's office, with the exception of Forteo, Olumiant, Humatrope, and Taltz, which are dispensed to the patient's home by Covance Specialty Pharmacy, unless otherwise specified by prescriber.)

Phone: (______) _______ - ________ Fax: (______) _______ - ________

State License #: ____________________________

Medication request and Refill Information: Completion of this section is OPTIONAL for the healthcare provider/prescriber, PROVIDED an actual hard copy prescription is submitted with the application. Forteo, Humatrope, Olumiant, and Taltz REQUIRE an actual hard copy prescription with the healthcare provider's/prescriber's signature. For your convenience, an Emgality, Forteo, Humalog Junior KwikPen, Humatrope, Humulin R U-500, Olumiant, and Taltz optional prescription templates can be found on the Lilly Cares website Resource page (www.lillycares.com) or may be faxed to you at your request.

Patient Name: ____________________________________ Patient DOB: ______________________
Please print name

Medication Requested: ____________________________________ Strength: __________________

Sig: ____

Quantity to be Dispensed: 4 months (max) 3 months 2 months 1 month

Refills #: ________ (up to one year of treatment) Date: __________

If prescribing insulin (required):
Units of insulin per dose: ________________
Max. units of insulin per day: ______________

Confirm insulin formulation (required):
☐ Vial (not available for Basaglar® or Humalog® U-200)
☐ KwikPen® (not available for Humulin® R 100 units/mL)
☐ Cartridge (only available for Humalog® 100 units/mL)

Prescriber Signature: ______________________________ ______________________________
Dispense as written ***Substitution/brand exchange permitted***

Prescriber must manually sign. Rubber stamps, signature by other office personnel for the prescriber and computer-generated signatures will not be accepted.

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Medication orders may be written for up to a 1-year supply, subject to program eligibility limits. Up to a 120-day supply is available in each shipment, unless a lesser amount is prescribed or provided per program guidelines.

Refills: A Lilly Cares Refill Authorization Form is located at the www.lillycares.com Resource page which may be completed and faxed to Lilly Cares, or a refill can be requested by calling 1-800-545-6962. If the prescription has not changed from the original approved application, the refill request will be processed. If any part of the prescription has changed, a new prescription will be required. If the prescriber has changed, the new prescriber will complete and sign the Healthcare Provider/Prescriber Section of the Lilly Cares application and provide a new prescription.

Healthcare Provider's/Prescriber's Confirmations and Agreements:

The Lilly Cares Foundation agrees, to the extent consistent with its exempt purposes, qualified under Section 170 (e) (3) of the Internal Revenue Code, and authorized by Lilly Cares policies, to provide medicines, prescription drugs, and other pharmaceutical products, medical supplies, and property (the "Medications") to the prescriber (the "Prescriber") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States which includes Puerto Rico (the "Qualifying Patients").

By signing below, I (the Prescriber) agree to the following terms and conditions:

- I will accept the Medication from Lilly Cares (except Forteo, Humatrope, Olumiant, and Taltz, when dispensed to the patient home) and deliver the Medication only to the Qualifying Patient named on this form at no charge of any kind. I will not use any of the Medication for any other purpose. This Medication will not be offered for sale, trade, or barter; returned for credit; nor will reimbursement be sought or claims be made for the Medication to any third party, including, but not limited to Medicare, Medicaid, or any benefit provider.
- I further certify that the patient is aware of, has consented to, and has directed my disclosure of their information to Lilly Cares so that Lilly Cares may contact the patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the patient therapy.
- I will give Lilly Cares 90 days advance notice if I need to assign this agreement, in full or in part, to another Prescriber.
- I am licensed and will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the state in which I am prescribing, receiving, storing, and dispensing the medication identified on this application to the patient listed in this application. I prescribed the medication to this patient based on my independent clinical judgment that treatment with this medicine for this patient is medically necessary.
- Lilly Cares has the right to contact the Qualifying Patient directly to make sure that the Medication was received.
- Lilly Cares has the right to revise or terminate the program at any time.
- All the Medications I have ever received from Lilly Cares were distributed only to Qualifying Patients.
- I agree to properly dispose of unused Medication.
- The information I provided is accurate to the best of my knowledge.

My signature below attests to my understanding and agreement to the above program requirements.

Prescriber Signature: ____ Date: _____________

Name of prescriber: ____
Please print name

Name of Lilly Cares applicant: ______________________________________ DOB: _____________
Please print name