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

Application Form Instructions

The Lilly Cares Foundation, Inc., an independent section 501(c)(3) private operating foundation, offers the Lilly Cares Patient Assistance Program ("Lilly Cares") to assist qualifying patients in obtaining certain Lilly medications at no cost.

What products are included?

Group A: For patients who are eligible for and have enrolled in Medicare Part D **OR** have no insurance.

- Basaglar® (insulin glargine injection)
- Cialis® (tadalafil)
- Cymbalta® (duloxetine delayed-release capsules)
- Effient® (prasugrel)
- Evista® (raloxifene hydrochloride)
- Forteo® (teriparatide [rDNA origin] injection)
- Glucagon™ (glucagon for injection [rDNA origin])
- Humalog® (insulin lispro injection)
- Humulin® (human insulin [rDNA origin])
- Prozac® (fluoxetine)
- Strattera® (atomoxetine)
- Symbyax® (olanzapine and fluoxetine)
- Taltz® (ixekizumab)
- Trulicity® (dulaglutide)
- Zyprexa®/Zyprexa® Intramuscular Zyprexa® Relprevv™/Zyprexa® Zydis (olanzapine)

Group B: For patients who are eligible for and have enrolled in Medicare Part D **OR** have no insurance **OR** those whose insurance does not cover the Lilly medication.

- Humatrope® (somatropin) for injection

Group C: For patients who have no insurance **OR** whose insurance does not cover the Lilly oncology medication. Patients may apply for Group C Lilly oncology medications by completing a different application. For information and/or to obtain an application, call 1-866-472-8663 or visit www.LillyPatientOne.com. PatientOne collects information on behalf of Lilly Cares for Group C.

Who qualifies for Lilly Cares?

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

- My healthcare provider has prescribed a Lilly medication for me.
- I am a permanent, legal resident of the United States.
- I am NOT enrolled in or eligible for Medicaid or Veteran's Administration benefits.
- If I am Medicare Part D eligible, I have enrolled in a Medicare Part D program.
- If I am a Medicare part D patient (except Forteo and Taltz patients), I have spent $1,100 on medication this calendar year.

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- My healthcare provider prescribed a Lilly medication in Group A and I have Medicare Part D **OR** no insurance
- My healthcare provider prescribed a Lilly medication in Group B and I have Medicare Part D **OR** no insurance **OR** my insurance does not cover the Lilly medication.
- **Humatrope Patients**—Patients with Medicaid or Veteran's Administration benefits may apply. Patients must submit a "no funding letter" from Humatrope Direct Connect which states they have no insurance benefits for their Humatrope therapy. Contact Humatrope Direct Connect at 1-84Humatrope (1-844-862-8767) if you need this letter. A "no funding letter" is not required for Medicare Part D patients.
- My yearly household income is less than the Annual Income Limit listed below:

Number of Persons in your Household	Annual Adjusted Gross Income Limit* If you live in Alaska or Hawaii, please contact us for annual adjusted gross income limits	
	Group A Products	**Group B Products**
1	$35,640	$59.400
2	$48,060	$80,100
3	$60,480	$100,800
4	$72,900	$121,500
5	$85,320	$142,200
6	$97,740	$162,900

**Note: These income limits are 300% (Group A Products) and 500% (Group B Products) of 2016 Federal Poverty Guidelines. Visit www.aspe.hhs.gov/poverty for information on the Federal Poverty Level. Federal Poverty guidelines may change yearly.*

These are just some of the Lilly Cares program eligibility requirements. If you meet the criteria listed here it does not guarantee you will ultimately qualify for Lilly Cares.

How do I apply?

To apply to Lilly Cares, complete the following 6 steps:

1. Complete the Patient Section (page 4), **sign** the Patient Certification (pages 5-6), and return.
2. Have your healthcare provider complete the Healthcare Provider/Prescriber Section (page 7), **sign** the Healthcare Provider's/Prescriber's Confirmations and Agreements (page 8), and return along with a prescription for your medication.
3. If you have Medicare, attach a copy of the **front** of your Medicare Part D card.
4. Some people with limited income (approximately less than $16,038 individual, or less than $21,627 married couple living together) may be able to get Extra Help, known as Low Income Subsidy (LIS), to assist with costs related to a Medicare prescription drug plan. For assistance in determining if you qualify for LIS, please call the Social Security Administration at 1-800-772-1213. If your gross income is equal to or less than the income described, please submit a copy of a Low Income Subsidy (LIS) denial letter. Medicare Part D patients who qualify for full LIS are not eligible for Lilly Cares.
5. Select and copy appropriate proof-of-income documents as noted on page 4. Keep copies for your records.
6. Fax or mail the completed, signed application, prescription, copies of proof-of-income, and copy of Medicare Part D card and LIS denial letter (if applicable) to Lilly Cares. The fax number and mailing address are at the top of page 1.

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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 are a Medicare Part D patient and you qualify for Lilly Cares**:
  1. You and your healthcare provider will receive a letter notifying you of enrollment.
  2. You will be enrolled until the end of the calendar year and must apply again next year upon reaching your out-of-pocket pharmacy spend for the next calendar year (except Forteo and Taltz patients).
  3. You will pick up your medication from your healthcare provider in 3-4 weeks. (Forteo, Humatrope, and Taltz generally require home delivery due to medication handling, and the patient will be contacted to schedule home delivery.)
- **If you are under the age of 65 and NOT a Medicare Part D patient and 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. After 12 months, you must apply again.
  3. You will pick up your medication from your healthcare provider in 3-4 weeks. (Forteo, Humatrope, 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

Patient Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: ___/___/____
Month Day Year

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Patient Income Information

Number of family members living in your household: _____

Total household annual (yearly) adjusted gross income: _____

1. **Proof of income—send copies only, no originals**: Send at least 1 document that shows your income or no income—such as documents listed below:
   - Copy of last year's Federal Income Tax return
   - Copy of current pay stubs or earnings statements
   - Copy of Social Security Income yearly benefit statement
   - Copy of W-2 or 1099 Form
   - Copy of unemployment benefit statement
   - Copy of statements of interest, dividends, or other income
2. **Additional proof of out-of-pocket pharmacy spend required for Medicare Part D patients (except Forteo and Taltz patients)**: Send proof that you have spent $1,100 (except Forteo and Taltz patients) on prescriptions this year. This can be an Explanation of Benefits (EOB) statement or summary from your pharmacy where you get your prescriptions filled.

If you do not know which documents to send, please call Lilly Cares at 1-800-545-6962.

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 message. (Standard text message and data rates apply.)
- 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: _____

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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.
- I am **NOT** enrolled in or eligible for Medicaid or Veteran's Administration benefits. (Humatrope patients may be eligible.)
- If I am a Medicare Part D patient (except Forteo and Taltz patients), I have spent $1,100 on prescriptions this year.
- My healthcare provider prescribed a Lilly medication in Group A and I am eligible for and have enrolled in Medicare Part D **OR** have no insurance.
- My healthcare provider prescribed a Lilly medication in Group B and I am eligible for and have enrolled in Medicare Part D **OR** have no insurance **OR** my insurance does not cover the Lilly medication.

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

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 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 and 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 patient, 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 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 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. 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

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Healthcare Provider/Prescriber Section

Name of Lilly Cares applicant: _____ Date of Birth: _____

Healthcare provider/prescriber: _____ (circle: M.D. D.O. N.P. P.A.)

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, Humatrope, and Taltz, which are dispensed to the patient's home by Covance Specialty Pharmacy, unless otherwise specified by prescriber.)

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

State License #: _____ Expiration date: _____

DEA #: _____ Expiration date: _____
(Required for requests of controlled substances)

Prescription 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, and Taltz REQUIRE an actual hard copy prescription with the healthcare provider's/prescriber's signature. For your convenience, a Forteo, Humatrope, and Taltz prescription template can be found on the Lilly Cares website Resource page (www.LillyCares.com) or will be faxed to you during the application review process.

Patient Name: _____ Patient DOB: _____

Product Requested: _____ Strength: _____

Sig: _____

If prescribing insulin: Units of insulin per dose: _____ Max. units of insulin per day: _____

Quantity: _____ (max 4-month supply) Date: _____

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 (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, 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 have made my patient aware that I am releasing their personal health information to Lilly Cares for treatment purposes.
- 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 to practice and dispense medicine, including the Medication, 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 this Medication to the above Qualifying Patient.
- 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.

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

Prescriber Signature: _____ Date: _____

Name of Lilly Cares applicant: _____ DOB: _____

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