Lilly Cares

P.O. Box 13185
La Jolla, CA 92039
www.LillyCares.com
Phone: 1-800-545-6962
Fax: 1-844-431-6650

Lilly Cares Refill Authorization Form

Patient Name: _____

Address: _____

DOB: _____ **DATE:** _____

Lilly product: _____ **Strength:** _____

Sig: _____
(If insulin, please include maximum daily dose)

Quantity to dispense: _____ **(max. 4-month supply)**
Please follow your state's regulation regarding the issuance of prescriptions.

Healthcare Provider's Attestations and Agreement to Participate in Lilly Cares Patient Assistance Program:
Lilly Cares agrees, to the extent consistent with its exempt purposes, qualified under Section 170(e)(3) of the Internal Revenue Code of 1986, as amended (the "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 "Healthcare provider") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients"). The Healthcare provider agrees to accept the Medications from Lilly Cares and deliver the Medications only to Qualifying Patients at no charge of any kind and further agrees not to use any of the Medications for any other purpose. The Healthcare provider agrees to provide Lilly Cares ninety (90) days advance notice of any proposed assignment, in full or part, of this agreement.
My signature immediately below attests to my understanding and agreement to the above Program requirements. I further attest that I am licensed in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above patient and will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the states in which I am prescribing, receiving, storing and dispensing Medications. I further attest that if Medications are received from Lilly Cares as a result of this application, I will accept such Medications and Medications will only be provided to the patient named on this form at no charge. I further attest that this Medication will not be offered for sale, trade, or barter. I understand that Lilly Cares has the right to contact the patient directly to confirm receipt of the Medications, and to revise or terminate the Program at any time. I further attest that all Medications previously received from Lilly Cares and distributed by me were distributed only to Qualifying Patients. I agree to properly dispose of any unused Medication.

I authorize Lilly Cares to act on my behalf for the limited purposes of transmitting this order for prescription medication.

Signature: _____ _____

Dispense as written **Substitution/brand exchange permitted**

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

Date: _____ License # _____ State of licensure: _____

DEA # _____ (as required) Telephone: _____ FAX: _____

Shipping information (NO PO BOX or THIRD PARTY VENDOR): Prescriber Name and Title: _____

Prescriber's Office/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____