LILLY CARES Patient Assistance Program Application

The Lilly Cares Foundation, Inc. ("Lilly Cares") is a nonprofit organization that offers a patient assistance program ("Program") to help qualifying patients obtain certain Eli Lilly and Company ("Lilly") medications at no cost. This Application Form is for patients who would like to apply to receive the available medication(s) at no cost through the Program.
Please complete and submit by fax or mail, or you may choose to apply online at www.lillycares.com.

What medications are provided by the Lilly Cares Program?

Group 1 Medications	Group 2 Medications	Group 3 Medications
Cialis® (tadalafil)	BAQSIMI™ (glucagon) nasal powder	Humatrope® (somatropin) for injection
Cymbalta® (duloxetine delayed-release capsules)	Basaglar® (insulin glargine injection)	Olumiant® (baricitinib) tablets
Evista® (raloxifene hydrochloride)	Emgality® (galcanezumab-gnlm) injection	Taltz® (ixekizumab) injection
FORTEO® (teriparatide [rDNA origin] injection)	Glucagon (glucagon for injection [rDNA origin])	
Prozac® (fluoxetine)	Humalog® (insulin lispro injection)	
Strattera® (atomoxetine)	Humulin® (human insulin)	
Symbyax® (olanzapine and fluoxetine)	REYVOW® (lasmiditan)	
Zyprexa® (olanzapine)	Trulicity® (dulaglutide)	

Patients may apply to Lilly Cares to receive prescribed Lilly oncology medications by completing an online or printable application form at www.lillycares.com. Patients may also call 1-800-545-6962 to request an application.

Who qualifies for the Lilly Cares Program?

To qualify, you must meet the requirements listed below:

- You are a permanent, legal resident of the United States, Puerto Rico, or U.S. Virgin Islands.
- Your healthcare provider has prescribed a Lilly medication listed above.
- You have **no** insurance including Medicaid, full Low Income Subsidy (LIS, "Extra Help") or Veterans (VA) Benefits (Humatrope patients with VA and Medicaid benefits may be eligible).
- For Group 3 Medications: You have Medicare Part D insurance coverage (Humatrope patients: Call Lilly Cares to review eligibility requirements).
- Your annual household income is less than the Annual Adjusted Gross Income Limit listed below:

Total Number of People in your Household (including you)	**Annual Adjusted Gross Income Limit** Based on 2020 Federal Poverty Level (FPL) Guidelines. See www.aspe.hhs.gov/poverty for more information.		
	Group 1 Medications (at or below 300% FPL)	**Group 2 Medications (at or below 400% FPL)**	**Group 3 Medications (at or below 500% FPL)**
1	$38,280	$51,040	$63,800
2	$51,720	$68,960	$86,200
3	$65,160	$86,880	$108,600
4	$78,600	$104,800	$131,000

If you live in Alaska, Hawaii, or have more than four people in your household please call us at 1-800-545-6962 for adjusted gross income limits.

How do I apply?

1. **Complete** the Patient Section (pages 2-4); **sign** the Patient Certification on page 4.
2. **Ask** your healthcare provider to **complete** the Healthcare Provider/Prescriber Section (page 5), **sign** the prescription (page 5) and Healthcare Provider's/Prescriber's Confirmations and Agreements (page 6), and return.
3. **Fax** or **mail** the following documents to Lilly Cares at 1-844-431-6650 *or* PO Box 13185, La Jolla, CA 92039:
   a) The completed and signed application,
   b) A copy of proof-of-income documentation, such as last year's Federal Income Tax return, a wage statement (IRS Form W-2), or Social Security Benefit Statement (Form SSA-1099),

Send copies of supporting documentation only. Do not send original statements (documentation provided to Lilly Cares will not be returned).

After we review your application, we will send a letter to you and your healthcare provider notifying you of whether you qualify for the Lilly Cares Program. If you qualify for Lilly Cares:

- You and your healthcare provider will receive a letter notifying you of enrollment.
- You will be enrolled for 12 months. If you are Medicare Part D patient, you will be enrolled through the end of the calendar year.
- The medication will either be shipped to your home or to your healthcare provider. We will contact you to schedule home shipment, if applicable.

If you do not qualify for Lilly Cares, we will send a notice to you and your healthcare provider.

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PATIENT SECTION

All fields are required. Please print clearly.

Patient Name: (Last)		(First)		(MI)	
Date of Birth: (Month/Day/Year)		Preferred Phone:	(_______) ________ - ____________		
Address:					
City:		State:		Zip:	

Where would you like your medication delivered?* ☐ To my home ☐ To my healthcare provider's office
*Consult with your healthcare provider to confirm delivery location.

Patient Income Information

Number of persons living in your household, including you:		Total household annual (yearly) adjusted gross income:	

You must submit proof of income with your application

Insurance Information

Do you have insurance? (check all that apply)

☐ Medicaid	☐ Medicare Part D	☐ Private/Commercial Insurance (e.g., employer sponsored plan, Health Insurance Marketplace plan)
☐ VA or Military	☐ None	☐ Other:

Authorization to Receive Text Message Notifications [Optional]

If your application is **approved**, we can send you text messages about the Program throughout your enrollment period. These text messages are optional. You can participate in Lilly Cares without signing up for text messages.

When you sign up for the text messages (by providing your cell phone number below), you must agree to the following conditions:

- Lilly Cares will send 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.
- Lilly Cares is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- Be aware that anyone who can open or have access to your phone might see your text messages.
- If your mobile operator is not participating in this service you will not receive messages.
- These text messages are NOT reminders 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 text messages, you must provide your cell phone number: ______________________________

Authorization for Automatic Prescription Refills ("Auto-refill")

Our auto-refill program will automatically fill your medication when you are due for a refill. If you've opted-in to text messages, we will send you a text message letting you know when your medication has shipped. When you have zero refills remaining, we will contact your healthcare provider for a prescription renewal before your next refill due date. Auto-refills will stop at the end of your program enrollment period. If you no longer need the medication, contact Lilly Cares at 1-800-545-6962.

☐ Yes, automatically fill my medication when I am due for a refill.
☐ No, do not automatically refill my medication. I will call Lilly Cares when I am due for a refill.

Authorization to Speak with Authorized Representative [Optional]

You may provide the names of one or more people with whom you authorize Lilly Cares to speak with on your behalf about this application or your participation in the Lilly Cares Program.

These people can provide or receive your personal information as necessary until you terminate their authority. Their authority will not automatically terminate once we process your application. Their authority will terminate at the end of your enrollment period.

By providing the name(s) below, you certify that individuals are aware and agree that you will provide their name to Lilly Cares for the purpose of serving as your 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 Lilly Cares at 1-800-545-6962.

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Privacy Notice:
We may use and save your personal information to meet legal or regulatory obligations that are in the legitimate interest of Lilly Cares, to fulfill legitimate and lawful business purposes in accordance with Lilly Cares' record retention policies and applicable laws and regulations, and to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests.

We may transmit personal information about you to Lilly and its affiliates worldwide (who may be assisting with the administration of Lilly Cares). These affiliates may in turn transmit personal information about you to other Lilly affiliates. Some of Lilly's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Lilly's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about privacy practices, including the basis for transfers and safeguards in place for cross-border transfers of personal information, please contact privacy@lilly.com or visit https://www.lilly.com/privacy.

We provide reasonable physical, electronic and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Lilly Cares. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches. We do not sell personal information.

Upon verification, you have the right to request information from us regarding how your personal information is being used and with whom that information is being shared. You also have the right to request to see and get a copy of the personal information that we have about you, request its correction or request its erasure/deletion.

There may be exceptions that apply to your request.

In limited circumstances, you may have the right to have your information transmitted to another entity or person in a machine-readable format. You will not be discriminated against for exercising any of your rights.

To exercise your rights, you or your authorized representative may submit a request by contacting us using one of the methods listed below.

You may make any of the above requests by contacting us at:
Lilly Cares Foundation Patient Assistance Program
PO Box 13185
La Jolla, CA 92039
Phone: 1-800-545-6962

If you wish to raise a complaint on how we have handled your personal information, you can contact the Global Privacy Office and Data Protection Officer at privacy@lilly.com who will investigate the matter for Lilly Cares.

If you are not satisfied with our response or have any concerns about how your data is being processed you can register a complaint with a relevant regulatory authority (e.g., a Data Protection Authority (DPA) or Attorney General).

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PATIENT CERTIFICATION (AGREEMENT)

I understand that:

- Lilly Cares will decide if I qualify for the Program. I understand that my application might not be approved.
- Lilly Cares may change or end the Program, or terminate my enrollment in the Program, at any time.
- **Lilly Cares does not charge a fee to apply for participation in the Program**. 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 Lilly Cares.
- If approved, my enrollment in the Program will expire at the end of the calendar year (if I am a Medicare Part D patient) or after 12 months. After my enrollment expires, I will need to reapply to the Program.

I certify (agree) that:

- I am a permanent, legal resident of the United States, Puerto Rico, or U.S. Virgin Islands.
- My application is complete and accurate. I have been truthful about my insurance coverage and income.
- I will promptly provide documentation that proves the information I have provided in this application, if needed by Lilly Cares, including after any decision regarding qualification for the Program (failure to promptly provide complete and accurate documentation when requested may result in immediate termination of application review or removal from the Program if application has already been approved).
- If my application is approved:
  - I will notify Lilly Cares of changes to my income or insurance status.
  - I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Lilly Cares Program.
  - If I have Medicare Part D coverage, I will not seek to have the cost/value associated with the medication I receive through the Program counted as out-of-pocket costs for prescription drugs.
  - If I have Medicare Part D coverage, I will inform my Part D Plan about my enrollment in Lilly Cares.
  - I will not sell, trade, or transfer any medication I receive through the Program.

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, Lilly, 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 for the following purposes:

- To review your application to determine your eligibility 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.
- Track use of medication.
- To measure program performance and make program improvements
- We only ask for and share the PHI that we need to operate the program. We do not ask for any PHI that we don't need, but we may receive some in health records sent to us.
- You don't have to give permission to share your PHI with Lilly Cares, but we may not be able to assist you without it.

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

- This authorization allows those who rely on it to release my Protected Health Information for 1 year from the date I have signed it.
- After your PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again.
- 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 have been provided a copy of this authorization.

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

(Signature Required)

Patient Printed Name: ____

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HEALTHCARE PROVIDER/PRESCRIBER SECTION

Patient Information (all fields are required):

Patient Name:		Date of Birth:			
Address:		Phone:			
City:		State:		Zip Code:	
Drug Allergies:					
Other Medications:					

Rx: I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy.					
Medication:		Strength:		Today's date:	
Directions (Please Print):					
Quantity to be Dispensed:	☐ 4 months (max)	☐ 3 months	☐ 2 months	☐ 1 month	
Refills #:	(up to one year of treatment)	Maximum dose per day:			

If prescribing insulin (required):	**Confirm insulin formulation (required):**
Units of insulin per dose: Max. units of insulin per day:	☐ 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)

Your state may require that prescriptions follow certain content requirements or use a particular form. By signing below, you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing. I authorize Lilly Cares to act on my behalf for the limited purposes of transmitting this order for prescription medication.

Prescriber 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.

Healthcare Provider Information (all fields are required):

Printed Prescriber Name and Title:		DEA # (as required):			
State License # and State:		NPI #:			
Phone:		Fax:			
Address:					
City:		State:		Zip Code:	

Note: If the patient's application is approved, medication will be delivered to the location selected by the patient in the patient section of this application (page 2). Please coordinate with your patient to ensure appropriate delivery location.

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

By signing below, I (the "Prescriber") certify to the following statements:

- I prescribed the above-referenced medication (the "Medication") to the patient listed on this form ("Patient") based on my independent clinical judgment that treatment with this Medication for the Patient is medically necessary.
- When requested by or required for my Patient and in accordance with his/her needs, Lilly Cares agrees, to the extent consistent with its tax exempt purposes, qualified under Section 170(e)(3) of the Internal Revenue Code, and authorized by Lilly Cares policies, to provide medications to Prescriber for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (including Puerto Rico and U.S. Virgin Islands). If Medication is shipped to my office, I will accept the Medication from Lilly Cares and deliver the Medication *only to* the Patient named on this form. I will provide this Medication 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.
- Prior to signing this form, I have ensured 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 a licensed prescriber, and I will comply with and abide by the dispensing laws applicable to the state in which I am prescribing, receiving, storing, and dispensing the Medication. I also will comply with applicable laws related to disposal of, and will properly dispose, unused Medication.
- I understand that Lilly Cares has the right to revise or terminate the Program at any time.
- 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

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