LILLY CARES® FOUNDATION 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) tablets	Baqsimi® (glucagon) nasal powder	Humatrope® (somatropin) for injection
Cymbalta® (duloxetine delayed-release capsules)	Basaglar® (insulin glargine injection)	Olumiant® (baricitinib) tablets
Evista® (raloxifene hydrochloride) tablet	Emgality® (galcanezumab-gnlm) injection	Taltz® (ixekizumab) injection
Forteo® (teriparatide injection)	Glucagon™ (glucagon for injection)	
Prozac® (fluoxetine capsules)	Humalog® (insulin lispro injection)	
Strattera® (atomoxetine) capsules	Humulin® (human insulin)	
Symbyax® (olanzapine and fluoxetine) capsules	Lyumjev™ (insulin lispro-aabc) injection	
Zyprexa® (olanzapine)	Reyvow® (lasmiditan)	
	Trulicity® (dulaglutide) injection	

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 or you have Medicare Part D.
- You are not enrolled in Medicaid, full Low Income Subsidy (LIS, "Extra Help") or Veterans (VA) Benefits
- Your annual household income is less than the Annual Adjusted Gross Income Limit listed below:

Annual Adjusted Gross Income Limit

Based on 2022 Federal Poverty Level (FPL) Guidelines. See www.aspe.hhs.gov/poverty for more information.

Total Number of People in your Household (Including you and all family members)	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	$40,770	$54,360	$67,950
2	$54,930	$73,240	$91,550
3	$69,090	$92,120	$115,150
4	$83,250	$111,000	$138,750

** 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?

Complete the Patient Section (pages 2-4); read and acknowledge the Consent, Terms and Conditions, and Privacy Notice in this document, **sign** the Patient Certification on page 4.

1. **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.

2. **Fax** or **mail** the completed and signed application to Lilly Cares at 1-844-431-6650 *or* PO Box 13185, La Jolla, CA 92039.

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

PATIENT SECTION

Patient Information [REQUIRED] Please print clearly.

Patient Name: (Last)		(First)		(MI)	
Date of Birth: (Month/Day/Year)					
Address:					
City:		State:		Zip:	

Where would you like your medication delivered? [1] ☐ To my home ☐ To my healthcare provider's office

[1]Consult with your healthcare provider to confirm delivery location.

Preferred Telephone: [2] (____) _____-_____

[2]By providing your telephone number and signing this form, you agree to receive automated phone or text message notifications from Lilly Cares, which may include updates on your enrollment status or medication shipments. You understand that you are not required to provide your phone number in order to apply to Lilly Cares. Message and data rates may apply. You understand you can opt-out 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).

Patient Income Information [REQUIRED]

Number of persons living in your household (including you and all family members):		**Annual Household Income before taxes** (Include wages, Social Security payments, disability and/or unemployment benefits, pensions, and any other income of yourself and those in your household)*:	

***When processing your application, Lilly Cares may contact you and require that you provide documentation showing your income.**

Patient Insurance Information [REQUIRED]

Do you have insurance (check all that apply)?

☐ None ☐ Medicare Part D ☐ Medicaid

☐ VA or Military ☐ Private Insurance (excluding Medicare Part D)** ☐ Other _____

**e.g., employer sponsored plan, Health Insurance Marketplace plan

✓ **PLEASE NOTE: Not signing page 4 of this form and providing ALL required information above will delay the processing of your application.**

Patient Authorization for Automatic Prescription Refills ("Auto-refill") [Optional]

If your prescription allows refills, Lilly Cares can automatically fill your medication when you are due for a refill. If you've provided your cell number, 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 or when your prescription has no more renewals. If you no longer need the medication or to opt out of auto-refills, 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.

Patient 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 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 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 change or remove Authorized Representative(s) at any time by calling Lilly Cares at 1-800-545-6962.

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).

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 my application is approved, my approval letter will tell me when my enrollment will expire (generally in 12 months or at the end of the calendar year for those with Medicare Part D). After my enrollment expires, I will need to reapply to the Program.
- For infused medications, I must have received treatment within 180 days of application approval, if granted.
- If I do not sign or refuse to sign this form, I will not be eligible for 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 meet the Program eligibility criteria, including income and insurance coverage requirements, as shown on page 1 of this application.
- I will promptly provide documentation supporting the information I have provided in this application (e.g., income verification documents) if such documentation is requested by Lilly Cares. (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).
- 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, and address 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 for the Program. This 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 Lilly Cares may request proof of my annual income as a requirement of enrollment in Lilly Cares.
- 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:

I understand that I or my healthcare provider's office is submitting this application to see if I qualify for assistance with my Lilly medications through Lilly Cares. I understand that before Lilly Cares can assist me, Lilly Cares may need to collect, use, and share information about me. When I sign below, I am authorizing any pharmacy, healthcare provider, and or others who are in possession of my personal information, including protected health information (PHI), to share information about me 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, I understand and am authorizing the Receiving Entities to share, use, and disclose my 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:

- 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 program representatives can contact me to collect any additional information needed to provide these services to me.
- This authorization allows those who rely on it to release my Protected Health Information for 3 years from the date I have signed it unless I am a resident of Maryland, Maine or Montana, in which case the permission will last for 1 year from the date of signature.
- 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.

Signature of Patient or Legal Guardian: _____ **Date**: _____

(SIGNATURE REQUIRED)

Printed Name of Patient: _____

Not signing this form will result in an incomplete submission and a delay in requested services.

HEALTHCARE PROVIDER/PRESCRIBER SECTION

Patient Information (all fields are required):

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.

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, confirm formulation (required):

☐ Vial (not available for Basaglar®, Humalog® U-200, or Lyumjev™ 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:	
Office Contact Name:		Office Contact Phone:			

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.
- I acknowledge that Lilly Cares will only provide the Medication (when requested or required for Patient and in accordance with his/her needs), 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, which may include the providing of the Medication 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.
- I understand that fax communications sent to a single number may split to multiple Receiving Entities for the purpose of operating the Program.
- 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: _____ **Date of Birth** (Month/Day/Year): _____
Please print name

Not signing this form will result in an incomplete submission and a delay in requested services