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 enrollment form is for patients who have been prescribed one of the following Lilly medications and would like to apply to receive the medication free of charge from Lilly Cares if they qualify:

- Alimta® (pemetrexed for injection)
- Cyramza® (ramucirumab)
- Erbitux® (cetuximab)
- Portrazza® (necitumumab)
- Retevmo™ (selpercatinib)
- Verzenio® (abemaciclib)

To qualify, patients must meet ALL the requirements listed below:

✓ You are a permanent, legal resident of the United States, Puerto Rico or U.S. Virgin Islands.

✓ You have been prescribed a Lilly Oncology medication for an FDA-approved indication and/or compendia use.

✓ You have no insurance or your insurance does not cover the prescribed Lilly oncology medication. If you have insurance that does not cover the medication, you must submit documentation that the insurance has denied the initial claim and one appeal. Your healthcare provider (HCP) or specialty pharmacy may be able to assist you with obtaining this documentation. If your HCP or specialty pharmacy needs assistance with obtaining the documentation, they may contact the Lilly sponsored Lilly Oncology Support Center at 1-866-472-8663.

✓ You have Medicare Part B, but have no supplemental or secondary insurance (e.g., private insurance offered by former employer, Medigap, Medicare Advantage).

✓ You are not enrolled in Medicaid, full Low Income Subsidy (LIS, "Extra Help") or Veterans (VA) Benefits.

✓ The treatment must be provided in an outpatient setting.

✓ For infused medications, you must have received treatment within 180 days of application approval.

✓ Your Annual Household Income must be at or below 500% of the Federal Poverty Guidelines. Visit (https://aspe.hhs.gov/poverty-guidelines) for information on the Federal Poverty Guidelines. (See table below)

Total Number of Persons in your Household (including applicant)	1	2	3	4	5	6
Annual Adjusted Gross Income Limit*	$63,800	$86,200	$108,600	$131,000	$153,400	$175,800

*If you live in Alaska or Hawaii, please contact us for annual adjusted gross income limits.

Application Form Instructions

Step 1 — Complete the Application

- Complete the whole application, including the Patient Section on pages 2-4 and the Healthcare Provider/Prescriber section on pages 5-6, or apply online at www.lillycares.com.

Step 2 — Include Appropriate Documentation About Patient's Income

Step 3 — Sign the Application

- The Patient must sign the Patient Agreement and Consent.
- The Prescriber must manually sign the Healthcare Provider/Prescriber Acknowledgment. Rubber stamps, signature by other office personnel for the prescriber and computer-generated signatures will not be accepted.

Step 4 — Submit the Application

- Fax or mail the completed application and any supporting documents to Lilly Cares. We recommend that you return the completed application by fax at 1-888-242-6230 in order to speed up the process.
- Incomplete or incorrect information will delay the process, so please make sure all information is provided correctly and signatures are obtained.

Patient Section **All fields are required. Please print.**

Patient Name (Last, First, MI)					
Address					
City		**State**		**Zip**	
Date of Birth (mm/dd/yyyy)		**Preferred Phone (xxx-xxx-xxxx)**			

Patient Income Information

Annual Household Adjusted Gross Income		**Total Number of People in Household (including applicant)**	

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.

Patient Insurance Information

Do you have insurance? (check all that apply)		
☐ Medicaid	☐ Medicare Part B *without* supplemental/secondary insurance*	☐ Medicare Part D
☐ VA or Military	☐ Medicare Part B *with* supplemental/secondary insurance*	☐ Private Insurance**
☐ None	☐ Other:	

*e.g., Medigap, Medicare Advantage, Employer private insurance **e.g., employer sponsored plan, Health Insurance Marketplace plan

Optional Text Message Notification of Approval for Verzenio and Retevmo

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 the text messages.

When you sign up for the text messages (by providing cell phone number below), you must agree to the following conditions: Lilly Cares will send an autodialed, pre-recorded message (Standard text message and data rates apply).

- Lilly Cares is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- You can opt out at any time by calling 1-800-545-6962.
- If your mobile operator is not participating in this service you will not receive messages.
- Be aware that anyone who can open or have access to 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: _____

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 to on your behalf about this application or your participation in the Lilly Cares Program.

These individuals 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.

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

1. Print Name of Authorized Representative: _____

2. Print Name of Authorized Representative: _____

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 Agreement and Consent

PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL Lilly Cares at 1-800-545-6962. YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.

The Lilly Cares Foundation, Inc. ("Lilly Cares"), is a non-profit organization that offers a patient assistance program to help qualifying patients obtain certain Lilly medications at no cost.

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

- I have been prescribed a Lilly Oncology medication.
- I am a permanent, legal resident of the United States, Puerto Rico or U.S. Virgin Islands.
- I have no insurance or my insurance does not cover the prescribed Lilly oncology medication
- If I have Medicare Part B, I have no supplemental or secondary insurance (e.g., private insurance offered by former employer, Medigap, Medicare Advantage)
- I am not enrolled in Medicaid, full Low Income Subsidy (LIS, "Extra Help"), or Veterans (VA) Benefits
- The treatment is provided in an outpatient setting.
- For infused medications, I must have received treatment within 180 days of application approval, if granted.
- My Annual Household Income is at or below 500% of the Federal Poverty Guidelines

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

I understand that I or my doctor's office is submitting this application to see if I qualify for assistance with my Lilly oncology 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. This information is requested in this application. This information is called My Personal Information. It includes: My Protected Health Information (PHI), My financial information, and other personal information about me.

- My PHI may include:
  - Any information related to my healthcare insurance or plan benefits, including coverage limits.
  - Other information related to my health and treatment. This may include information that may be sensitive, relating to sexually transmitted diseases, mental health conditions, and/or genetic testing.
  - Information related to my health while I am in the Lilly Cares program, such as whether I'm staying on my medicine or treatment.
  - Some information that may not be related to my Lilly oncology medication and is not requested by Lilly Cares. This information may be sent only because it is part of my health care records.
- I understand that by signing this form, I am permitting the following providers to release My Personal Information, including my PHI, to Lilly Cares Program Representatives (defined below):
  - My doctor's office - My pharmacies - My healthcare plan or insurance company - Other providers
- Lilly Cares "Program Representatives" include the Lilly Cares Foundation, Inc., Eli Lilly and Company, Lilly USA, LLC, and their vendors, business partners, and agents who may be assisting Lilly Cares. I understand that to provide the services for Lilly Cares, the Program Representatives may need to share My Personal Information with other Program Representatives involved with Lilly Cares, and with my doctor's office or other healthcare providers, including my insurance company or health plan or pharmacies, or other patient assistance and charitable programs.
- I further understand that the Program Representatives will use My Personal Information in the following manner:
  - To review my application for the Lilly Cares program.
  - To contact me or my doctor's office or other of my healthcare providers, as necessary, to conduct such services.
  - For purposes relating to the operation and administration of the Lilly Cares program, including measuring and tracking the quality of the services.
  - To keep track of my use of Lilly oncology medicines provided by Lilly Cares.
- 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 also understand that the Program Representatives can contact me to collect any additional information needed to provide these services to me.
  - I agree to notify Lilly Cares of changes to my income or insurance status that may impact my eligibility for Lilly Cares.
- I understand if I do not sign or refuse to sign this form, I will not be eligible for Lilly Cares.
- This authorization allows those who rely on it to release my PHI for 1 year from the date I have signed it. I understand that I can withdraw it at any time by sending a written notice to Lilly Cares at PO Box 13185 La Jolla, CA 92039. My withdrawal goes into effect once it is received by Lilly Cares. I also understand that by withdrawing, I may not receive or I may stop receiving Lilly oncology medicines provided by 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 have read and understand**

X		**Date**	

Patient or Legal Guardian Signature

Printed Name of Patient or Legal Guardian

Healthcare Provider/Prescriber Information

Facility Name		**Facility NPI #**	
Healthcare Provider/ Prescriber Name		**(Circle: M.D. D.O. N.P. P.A. R.Ph. other _____)**	
Healthcare Provider/ Prescriber State License #		**HCP NPI #**	
Address			
City		**State**	**Zip**
Office Contact		**Office Phone**	
Phone Ext		**Fax**	

Prescription/Medication Order Information

Infused Medication Treatment Setting: ☐ **Healthcare Provider/Prescriber's Office** ☐ **Hospital/Clinic Outpatient**	
Name of Treatment Facility	
Address of Treatment Facility	

☐ **Product Replacement–Request product after dose administered** ☐ **Proactive Provision–Request product prior to administration**

Date		**ICD.10**	
Patient Name		**DOB**	
Patient Address		**Patient Phone**	
City		**State**	**Zip**
Drug Allergies			
Other Medications			
Infused Product Requested	☐ **Alimta** ☐ **Cyramza** ☐ **Erbitux** ☐ **Portrazza**	**Vial Size/Strength**	
Directions		**# of Vials**	
Scheduled Administration Dates		**Dosing Schedule/ Frequency**	

Complete this section for Verzenio and Retevmo. This medication will be shipped to patient's home.

Prescription for Verzenio® (abemaciclib) Tablets	**Prescription for Retevmo™ (selpercatinib) Capsules**
☐ **Verzenio:** 50 mg 7-day blister pack (NDC: 0002-4483-54)	☐ **Retevmo:** 80 mg 120-count bottle (NDC: 0002-2980-26)
☐ **Verzenio:** 100 mg 7-day blister pack (NDC: 0002-4815-54)	☐ **Retevmo:** 80 mg 60-count bottle (NDC: 0002-2980-60)
☐ **Verzenio:** 150 mg 7-day blister pack (NDC: 0002-5337-54)	☐ **Retevmo:** 40 mg 60-count bottle (NDC: 0002-3977-60)
☐ **Verzenio:** 200 mg 7-day blister pack (NDC: 0002-6216-54)	
Quantity: 1 month supply **Refills (up to 1 year):** _____	**Quantity:** 1 month supply **Refills (up to 1 year):** _____
Directions: 1 tablet twice daily	**Directions:** _____

Prescriber Signature (no stamps): I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize the Lilly Cares Program Representatives to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy, if applicable. 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 state in which you are prescribing

X		**X**	
Dispense as Written		**May Substitute**	

Printed Name of Prescriber	

Healthcare Provider/Prescriber Acknowledgment

By signing the below, I certify:

- The information provided is accurate to the best of my knowledge
- The therapy is medically necessary. I also represent that I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient, the Lilly Cares Foundation, Inc., Eli Lilly and Company, Lilly USA, LLC and their vendors, business partners, and agents (the "Program Representatives") for the purpose of assessing whether the patient qualifies for the Lilly Cares program through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Program Representatives so that Program Representatives may contact the patient to further enable these services
- I am licensed, 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
- I have prescribed this patient a Lilly oncology medication for an FDA-approved indication and/or compendia use
- To the best of my knowledge the patient meets the financial, insurance, and residency requirements of the Lilly Cares program. If I become aware the patient may no longer meet the criteria for the program, I agree to notify Lilly Cares
- I have not received and will not seek reimbursement or payment for all or any part of the benefit received by the patient through Lilly Cares
- Any medication provided by Lilly Cares for this patient will not be resold, nor offered for sale, trade or barter, or returned for credit
- An appeal to the insurer has been completed and I have received a denial for that appeal.

I understand:

- Lilly Cares may change, terminate, suspend participation, limit enrollment, or recall/discontinue medications in the program without prior notice
- I am under no obligation to purchase or prescribe any Lilly drug to participate in this program and I have not received nor will I receive any benefit from any Program Representatives for prescribing a Lilly drug
- Program Representatives are not responsible for filing any insurance claim
- The information provided will be subject to potential random reviews
- If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Lilly Cares will bill for the covered product, and I agree to be responsible for payment of the bill
- If I elect to receive medication from Lilly Cares under the Proactive Provision program, I certify that I will complete the required Administration Verification form confirming that the product has been administered to the applicable enrolled patient. I will notify Lilly Cares if any product is not administered to the applicable enrolled patient and will return the product to Lilly Cares for destruction or appropriately destroy the product at the facility and submit documentation to Lilly Cares confirming that the product has been appropriately destroyed. If I do not return or destroy the product provided and not used for the applicable enrolled patient, I will be billed for the product and I agree to be responsible for payment of the bill. Please contact Lilly Cares at 1-800-545-6962 for assistance with product returns.

		DOB	

Printed Name of Patient

X		**Date**	

Healthcare Provider/Prescriber Signature (no stamps)

Printed Name of Prescriber

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