

The Lilly Cares® Foundation Patient Assistance Program ("Lilly Cares") Diabetes Prescription FAX Form

Patient Name: _____		Date of Birth: _____		Today's Date: _____	
Address: _____					
City: _____		State: _____		Zip Code: _____	
Phone: _____					
Ship to Address (if different from patient address above, No P.O. Box or third-party vendor):					

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. To submit an electronic prescription, please select Fortrea Specialty Pharmacy (NPI 1780811125) in your eRx software.

Basaglar® (insulin glargine injection) <input type="checkbox"/> U-100 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____	Humalog® (insulin lispro injection) <input type="checkbox"/> U-100 vial <input type="checkbox"/> U-100 cartridge <input type="checkbox"/> U-100 KwikPen® <input type="checkbox"/> U-200 KwikPen® <input type="checkbox"/> U-100 KwikPen® Junior Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____	Humalog® Mix 50/50™ (insulin lispro protamine and insulin lispro injectable suspension) <input type="checkbox"/> U-100 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____		
Humalog® Mix 75/25™ (insulin lispro protamine and insulin lispro injectable suspension) <input type="checkbox"/> U-100 vial <input type="checkbox"/> U-100 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____	Humulin® N (isophane insulin human suspension) <input type="checkbox"/> U-100 vial <input type="checkbox"/> U-100 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____	Humulin® 70/30 (human insulin isophane suspension and human insulin injection) <input type="checkbox"/> U-100 vial <input type="checkbox"/> U-100 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____		
Humulin® R (insulin human injection) <input type="checkbox"/> U-100 vial Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____	Humulin® R U-500 (insulin human injection) <input type="checkbox"/> U-500 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____	Lyumjev™ (insulin lispro-aabc) <input type="checkbox"/> U-100 vial <input type="checkbox"/> U-100 KwikPen® <input type="checkbox"/> U-200 KwikPen® Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____		
Trulicity® (dulaglutide) injection <input type="checkbox"/> 0.75 mg/0.5 mL Pen <input type="checkbox"/> 3.0 mg/0.5 mL Pen <input type="checkbox"/> 1.5 mg/0.5 mL Pen <input type="checkbox"/> 4.5 mg/0.5 mL Pen Sig: _____ Quantity (per month supply): <input type="checkbox"/> 4 (max) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 Max dose per day: _____ Refills: # _____				

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.

Signature (REQUIRED): _____

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.

Printed Prescriber Name and Title: _____ **FAX:** _____
State License Number and State: _____ **NPI#:** _____ **Phone:** _____
Prescriber Office/Clinic Name and Shipping Address (No PO Box): _____

Patients prescribed the Humulin R U-500 vial must be prescribed the BD™ U-500 insulin syringe to avoid medication errors. Do not use another type of syringe. The U-500 insulin syringe is not available through Lilly Cares. The safety and efficacy of Humulin R U-500 delivered by continuous subcutaneous insulin infusion/pump has not been determined. Prescriber orders for Humulin R U-500 administered by continuous subcutaneous insulin infusion/pump will not be fulfilled.

IMPORTANT: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

Lilly Cares Foundation Patient Assistance Program

PO Box 501847 | San Diego, CA 92150 | Phone: 1-800-545-6962 | Fax: 1-844-431-6650 | www.LillyCares.com

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