## 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)
☐ U-100 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humalog®** (insulin lispro injection)
☐ U-100 vial ☐ U-100 cartridge
☐ U-100 KwikPen® ☐ U-200 KwikPen®
☐ U-100 KwikPen® Junior
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humalog® Mix 50/50™** (insulin lispro protamine and insulin lispro injectable suspension)
☐ U-100 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humalog® Mix 75/25™** (insulin lispro protamine and insulin lispro injectable suspension)
☐ U-100 vial ☐ U-100 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humulin® N** (isophane insulin human suspension)
☐ U-100 vial ☐ U-100 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humulin® 70/30** (human insulin isophane suspension and human insulin injection)
☐ U-100 vial ☐ U-100 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humulin® R** (insulin human injection)
☐ U-100 vial
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Humulin® R U-500** (insulin human injection)
☐ U-500 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Lyumjev™** (insulin lispro-aabc)
☐ U-100 vial ☐ U-100 KwikPen®
☐ U-200 KwikPen®
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 1
**Max dose per day:** _____ **Refills:** # _____

**Trulicity®** (dulaglutide) **injection**
☐ 0.75 mg/0.5 mL Pen ☐3.0 mg/0.5 mL Pen
☐ 1.5 mg/0.5 mL Pen ☐4.5 mg/0.5 mL Pen
**Sig**: _____
**Quantity (per month supply):** ☐ 4 (max) ☐3 ☐2 ☐ 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.***



**Lilly Cares Foundation Patient Assistance Program**
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