Lilly Cares patient assistance program

PO Box 230999
Centreville VA 20120
1-800-545-6962

Lilly Cares Foundation, Inc. ("Lilly Cares"), which is a nonprofit, tax-exempt charity affiliated with Eli Lilly and Company ("Lilly"), provides a patient assistance program that supplies certain medications, free of charge, to qualifying legal US residents without private, public, or Government prescription assistance who need temporary assistance in obtaining their Lilly medications. Patients cannot be Medicare-eligible.

- To apply, both the physician and patient must complete and sign this application.
- If the patient is enrolled, **medications are delivered to the prescriber and the prescriber dispenses** to the patient.
- Medications usually arrive at the prescriber's office **4 weeks** after Lilly Cares receives a completed application.
- Patients enroll for a 12-month period, and must re-apply annually.
- The prescriber's office requests refills by faxing the Fax Refill Request Form to Lilly Cares. (form enclosed with each medication shipment)

➢ *Step One: Prescriber - Complete section below (please print clearly)*

Prescriber's Name:____

M.D. D.O. N.P. P.A.

Mailing Address: Street:______________________________City:________________State:_______Zip:________

Shipping Address:____

(IF DIFFERENT FROM MAILING ADDRESS) (DO NOT USE PO BOX or THIRD PARTY VENDOR)

City:____State:________________Zip:________

Phone:(_______)______________________

Does patient have access to medication at zero or reduced cost through clinic facility? ☐ Yes ☐ NO

Medication Information: *(Prescriber to complete)*

Patient Name:____

Product Requested:______________________________________**Dosage:**______________________

Sig:____

Quantity:____

A 4-month supply of most products will be provided unless a lesser amount is requested.

Healthcare Provider's Attestations and Agreement to Participate in Program:

Lilly Cares agrees, to the extent consistent with its exempt purposes, qualified under Section 170(e)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and authorized by Lilly Cares policies, to provide medicines, prescription drugs, and other pharmaceutical products, medical supplies, and property (the "Medications") to the prescriber (the "Healthcare provider") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients"). The Healthcare provider agrees to accept the Medications from Lilly Cares and deliver the Medications only to Qualifying Patients at no charge of any kind and further agrees not to use any of the Medications for any other purpose. No responsibilities of the administration of this program are assignable to any third party.

My signature immediately below attests to my understanding and agreement to the above Program requirements. I further attest that I am licensed in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above patient. I further attest that if Medications are received from Lilly Cares as a result of this application, I will accept such Medications and Medications will only be provided to the patient named on this form at no charge. I further attest that this Medication will not be offered for sale, trade, or barter, or assigned to a third party for dispensing to the above patient. I understand that Lilly Cares has the right to contact the patient directly to confirm receipt of the Medications, and to revise or terminate the Program at any time. I further attest that all Medications previously received from Lilly Cares and distributed by me were distributed only to Qualifying Patients.

Prescriber Signature:____

Original Signature Only; No Photocopies or Stamps

Date:__________ /_________ /___________

State of license:____

State License #____

License expiration date: ____

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➢ *Step Two: Patient – Complete sections below (please print clearly)*

Patient Name:(Last)_____________________________(First)_________________________________(MI)__________
SSN:________________________-__________________-______________________________________
Address: Street:____ ________
City:____State:__________Zip:____________________
Date of Birth:_______________/__________/__________________Phone:(________)____________—____________________
Number of People in household: (Includes ALL people living in your household)____________________________________
Total Monthly Household Income: $_____________________

A copy of the first page of your most recent Income Tax Return, or other proof of income, including any source of income (SSI, SSDI, pension, unemployment, alimony, food stamps, etc.,) MUST be included with this application. Failure to include will result in rejection and return of application.

Insurance Information:

1. Are you eligible for Medicare? ☐Yes ☐No
2. Are you a veteran of the armed services, or eligible for V.A. benefits? ☐Yes ☐No
3. Do you have any prescription coverage? ☐ Yes: If yes, please list coverage:___________________________________
   (e.g. Medicare, Medicaid, or private prescription insurance)
   ☐No If NO, How do you pay for your prescriptions?
   ____
4. Do you have access to medication at zero or reduced cost through clinic facility? ______________________________
5. Do you have medical insurance? ☐ Yes ☐ No If NO, How do you pay for your doctor visit ?
   ____

Patient's Authorization and Certification: *patient must read and sign*

By my signature below, I confirm that I am a legal resident of the US and that I understand and that I authorize Lilly Cares, Lilly, and any entity that may be contracted to be the Program administrator of Lilly Cares ("Administrator"), to receive and to have access to the following information: (1) information contained in this application; (2) information on the prescription medications that my Healthcare provider has provided or will provide me; and (3) other information that Lilly Cares, Lilly, or the Administrator may obtain about me in operating and administering the Lilly Cares Program (the "Information").

By my signature below, I further authorize Lilly Cares, Lilly and the Administrator to use the Information in the following manner: (1) to review my application and to contact me or my Healthcare provider, as necessary, to conduct such review; (2) for purposes relating to the operation and administration of the Lilly Cares Program; and (3) for Lilly Cares' and Lilly's internal purposes involving patient assistance programs and charitable programs generally.

I understand that this Information will not be shared with other parties, but that certain non-personal portions of the Information (for example, general location, age, gender) may be shared with other parties for purposes of operating or analyzing Lilly Cares. I understand that I have the right to revoke this Authorization at any time by sending written notice to Lilly Cares at the address set forth on this application. If I revoke this Authorization, I will no longer be eligible for the services provided by the Lilly Cares Program. Canceling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed, but will not affect disclosures made before that time.

I certify that I am not age 65 years or older. I certify that I am neither eligible for Medicare nor currently receiving any benefits under Medicare. I understand that when I turn 65 years old or become eligible for Medicare, I will no longer be eligible for this Program and I agree to promptly notify Lilly Cares of my age and/or eligibility for Medicare at that time. I certify that the information I have set forth in this application is true, correct, and complete and I agree to abide by the rules, procedures and conditions of this program. I understand that eligibility under the Lilly Cares Program is subject to approval by Lilly Cares and/or the Administrator, and that application to the Lilly Cares Program does not guarantee inclusion in the Lilly Cares Program. I understand that the Lilly Cares Program may be changed or terminated at any time without prior notice.

Patient Signature: ____

Date:_______________ /_________________ /___________________

CAUTION: PLEASE COMPLETE ALL SECTIONS OF THIS APPLICATION.
INCOMPLETE APPLICATION WILL DELAY PROCESSING OF THE REQUEST.

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