

**FORTEO® (teriparatide [rDNA origin] injection)**  
**PATIENT ASSISTANCE PROGRAM**  
**Lilly Patient Assistance Program - FO**  
**PO Box 66746**  
**St. Louis, MO 63166-6746**  
**1-877-214-3475**

- Lilly USA, LLC (“Lilly”) provides this patient assistance program to qualifying legal US residents who need assistance in obtaining FORTEO.
- This blank form may be photocopied.
- To apply, the patient must submit this completed application and valid prescriptions, and meet certain eligibility criteria.
- Patients must supply valid prescriptions for both medication and needles.
- There is NO administrative fee associated with this program.
- Medication will be mailed to enrolled patients within approximately 2 weeks.

NOTE: Patients with any insurance coverage, including Medicare, are ineligible for this program. Information on Medicare is available by calling 800-Medicare or visiting [www.medicare.gov](http://www.medicare.gov).

**Please print clearly and complete all blanks**

<b>Step 1 - Physician Information</b>				
Physician Name:	Phone: (    )	Fax: (    )		
Address:	City:	State:	Zip:	
<b>Step 2 - Patient Information</b>				
Patient Name:			SS#:                    -                    -	
Street Address:		Date of Birth:                    /                    /		Male <input type="checkbox"/> Female <input type="checkbox"/>
City:	State:	Zip:	Phone: (    )	
Number of Household members (including self)? (circle one) 1   2   3   4   5   6   7   greater than 7	Legal US Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you receive disability benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you receive VA benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>	
List all patient medications:				
List patient allergies:				
<b>Financial Information Note:</b> You must attach a copy of your most recent US Income Tax Return (ie, IRS Form 1040, 1040A, 1040EZ, 1099).				
<b>List All Sources of <u>Gross Monthly</u> Amounts</b>				List your monthly Interest/Earnings from <b>Assets:</b>  \$ _____
Salary/Wages    \$ _____	Social Security \$ _____	Child Support/Alimony \$ _____		
Disability        \$ _____	Pension/Retirement    \$ _____	Unemployment/Work Comp	\$ _____	
<b>Total Gross Household <u>Monthly</u> Income: \$ _____</b>				
<b>Private Drug Coverage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Medicaid</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Medicare</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Step 3 – Patient Authorization and Certification (Patient must sign below)**

By my signature below, I confirm that I wish to enroll in the Lilly FORTEO patient assistance program (“Program”), and my signature below certifies that fact along with certifying the factual accuracy of the statements set forth below. I am a legal resident of the US; the information I have set forth below is true, correct, and complete; and I agree to abide by the rules, procedures, and conditions of this Program. I am NOT eligible for Medicaid or Medicare, and if I become eligible for any insurance coverage, including Medicaid or Medicare, I am no longer eligible for the Program, and I will notify Lilly USA, LLC (“Lilly”) of my current status. I attest that my physician or other healthcare provider has prescribed a Lilly medication covered in this Program. By signing this form I hereby certify and agree that: (i) I will not submit any claim for reimbursement to any third party insurer for any product provided to me under the Lilly program. I understand and agree to provide to Lilly, upon Lilly’s request, supporting documentation that verifies the assertions that I have certified to in this form. I acknowledge that my compliance with this certification is a condition of any assistance provided to me by Lilly.

I understand that Lilly and any entity it may contract with to be the administrator for this Program (referred to as the “Administrator”) will receive the information contained in this form, information on the prescription medicines that my prescriber has provided or will provide me, information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the Program, any information or data related to the Program from the date of my enrollment in the Program, any of my personal information and other information that they may obtain about me in appropriately operating and administering this Program (the “Information”). I hereby authorize the Administrator and/or Lilly to use and/or disclose the Information: (i) to review my eligibility and contact me, and/or my healthcare provider, as necessary to conduct such review and to keep me and my healthcare provider apprised of my enrollment status; (ii) for purposes relating to the operation and administration of this Program; and (iii) for Lilly’s internal business purposes involving patient assistance programs generally. I authorize any pharmacy to use and/or disclose to Lilly all Information relating to my participation in the Program. I understand that if my Information is disclosed, federal privacy laws may no longer protect the Information from further disclosure. I understand that my medical treatment and/or payment is not conditioned upon the signing of this Authorization. I understand that I have the right to revoke this Authorization at any time by writing Lilly at the address set forth on this form. If I revoke this Authorization, I will no longer be eligible for the Program. Canceling this Authorization will prohibit disclosures of my Information after the date the cancellation letter is received and processed, but will not affect disclosures made before that time. This Authorization expires at the end of my participation in the Program. I acknowledge that I have been provided a copy of this. I do not have any government or private insurance that covers or helps me pay for my medications. I understand that the Program described herein may be changed or terminated at any time without prior notice.

Patient’s or Legal Guardian’s Signature:

Date:

**APPLICATION CHECKLIST**

**QUESTIONS? Call 877-214-3475**

Be sure to COMPLETE ALL BLANKS! The most common cause of DELAY is MISSING INFORMATION! \_

- Mail: 1) this COMPLETED application **PLUS** your prescriptions for FORTEO and injection supplies  
2) a COPY of the first page of your most recent tax return, or, if no tax form exists, provide a COPY of other proof of income (for example, an SSA-1099)  
3) **ATTACH VALID PRESCRIPTIONS for both FORTEO and injection supplies**

Please do NOT send any other materials.