LillyMedicareAnswers Patient Assistance Program

PO Box 66977
St. Louis, MO 63166-6977
1-877-RXLilly or 1-877-795-4559

Thank you for your interest in the LillyMedicareAnswers Patient Assistance Program. The program is designed to provide certain medications to qualifying patients who need temporary assistance in obtaining their Lilly medications.

To qualify for the program, the patient must, among other things:

- be enrolled in US or Puerto Rico Medicare Part D
- be a legal US or Puerto Rico resident
- meet income requirements
- not have private drug coverage, or Veteran's benefits
- in US, be denied or ineligible for Low-Income Subsidy (Extra Help)
- in Puerto Rico, have a rejection letter from Medicare Platino, if applicable
- not be enrolled in US Medicaid or Puerto Rico's Government Health Insurance Plan (Plan de Salud del Gobierno de Puerto Rico)

The following actions are necessary to apply for the LillyMedicareAnswers Patient Assistance Program:

Step 1. Complete the physician information section of the attached application.

Step 2. Attach valid, newly written prescription(s) to the application. Note: injection supplies, if needed for administering your medication, require a valid, newly written prescription.

Step 3. Complete the patient information section of the attached application:

a. Complete the financial information section and attach a copy of the patient's most recent year income information
   - In US: IRS Form 1040, 1040EZ, 4506T, 1099, Social Security or Disability statement
   - In Puerto Rico: examples include Hacienda Form 481.0, 482.0, IRS Form 1040, 1040EZ, 4506T, 1099, Social Security or Disability statement

b. Complete the insurance information boxes at the bottom of page 1.
c. Complete the Medicare Part D Prescription Drug Plan Section of the application and attach a copy of your card, both front and back

Step 4. Sign the Patient Authorization and Certification section of the application.

Step 5. Mail the application, prescription(s), financial documentation, front and back copies of your Medicare card, and:
- In US: Low Income Subsidy (extra help) denial letter (if applicable)
- In Puerto Rico: a rejection letter from Government Health Insurance Plan or Medicare Platino (if applicable) to:

LILLYMEDICAREANSWERS
PO BOX 66977
ST. LOUIS, MO 63166-6977

After we receive your information, we will review your eligibility and process your application. Enrollees will be contacted, if necessary, to arrange medication shipment, which should arrive approximately 2 weeks after we receive your application. Denied applicants will be notified by mail.

If you have any questions, please call a LillyMedicareAnswers Patient Assistance Program representative at 1-877-RxLilly or 1-877-795-4559, Monday through Friday, 8:00 am to 5:00 pm, US Central Standard Time.

Thank you,

Lilly USA, LLC

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- This blank form may be copied.
- Lilly USA, LLC provides a patient assistance program that supplies certain medications to qualifying residents who need temporary assistance in obtaining their Lilly medications.
- To apply for this program, the patient must submit a completed application with required documentation, meet certain eligibility criteria, and reapply yearly.
- If the patient is enrolled, the first medication shipment will arrive within approximately 2 weeks after the application is received. If not enrolled, all documentation is returned to the patient.
- NOTE: Patients must be enrolled in a Medicare Part D Program. For information or help, patients may call 1-800-MEDICARE or visit www.medicare.gov.
- Eligible patients cannot receive assistance from US Medicaid, or Puerto Rico's Government Health Insurance Plan or Medicare Platino

Please print clearly and complete all blanks

Step 1 - Physician Information

Physician Name:	Phone: ( )	Fax: ( )	
Address:	City:	State:	Zip:

Step 2 - Prescription Information: valid prescription(s) must be attached with the application. Note: injection supplies require a valid prescription.

Step 3 - Patient Information

Patient Name:	SS#: - -		
Street Address:	Date of Birth: / /	Male ◯ Female ◯	
City:	State:	Zip:	Phone: ( )

Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 greater than 7	Legal Resident? Yes ◯ No ◯	Do you receive disability benefits? Yes ◯ No ◯	Do you receive Veteran's Admin benefits? Yes ◯ No ◯

List all patient medications:

List patient allergies:

Financial Information Note: You must attach a copy of your most recent US Income Tax Return (ie, IRS Form 1040, 1040A, 1040EZ, 1099).

List All Sources of Gross Monthly Amounts

Salary/Wages $_____ Social Security $_____ Child Support/Alimony $_____

Disability $_____ Pension/ Retirement $_____ Unemployment/ Work Comp $_____

Total Gross Household Monthly Income: $_____

List your monthly Interest/Earnings from **Assets**:

$_____

Private Drug Coverage	US Medicaid	Puerto Rico Plan de Salud del Gobierno -or- Medicare Platino	Medicare Part D
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

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Important Instructions: Patients must submit:

- **In US, a Low-Income Subsidy (Extra Help) denial letter if their income is 135% of the Federal Poverty Level or below based on household size.**
- **In Puerto Rico, a rejection letter from Government Health Insurance Plan or Medicare Platino (if applicable**

All patients must submit a copy of the front and back of their Medicare Part D Prescription Drug Plan Card. Patients also must complete the Medicare Part D Prescription Drug Plan and Consent sections below.

Medicare Part D Prescription Drug Plan Information

Prescription Drug Plan Name:	Group Code Number:
Prescription Drug Plan Phone Number:	
Prescription Drug Plan Address:	

City:	State:	Zip:

Step 4 – Patient Authorization and Certification (Patient must sign below)

By my signature below, I confirm that I wish to enroll in the LillyMedicareAnswers program the ("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. I am enrolled in a Medicare Part D Plan, AND 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, including my Medicare Part D Plan, for any product provided to me under LillyMedicareAnswers program. I am not eligible for Puerto Rico's Government Health Insurance Plan or Medicare Platino. I understand and agree to provide to LIlly USA, LLC ("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 will not claim true-out-of-pocket-cost ("TrOOP") from my Medicare Part D Plan for the value of the product provided to me under LillyMedicareAnswers and I understand that it is my responsibility to notify my Medicare Part D Plan of my enrollment in the LillyMedicareAnswers program. I hereby authorize the Administrator and/or Lilly to share data with the Centers for Medicare and Medicaid Services ("CMS") and/or my Medicare Part D Plan consistent with the terms of any Data Sharing Agreement agreed upon by Lilly and CMS or my Medicare Part D Plan. 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 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 Authorization. Other than a Medicare Part D Plan, 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 Signature:_____ Personal Representative:_____ Relationship to the Patient:	Date:_____ Date:_____

APPLICATION CHECKLIST:

- COMPLETE ALL BLANKS – MISSING INFORMATION WILL CAUSE A DELAY IN PROCESSING!
- INCLUDE Prescription(s)
- INCLUDE financial copies
- INCLUDE copy of Medicare card, both front and back
- SIGN CERTIFICATION