LillyMedicareAnswers Patient Assistance Program

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

- This blank form may be photocopied. To apply for the program, the patient must complete this application and meet certain eligibility criteria.
- Eli Lilly and Company ("Lilly") provides a patient assistance program that supplies certain medications, requiring a $25 administrative fee for each 1-month supply of medication, to qualifying U.S. residents who need temporary assistance in obtaining their Lilly medications.
- To apply for this program, the patient must complete this application and re-apply yearly.
- If the medication is approved for distribution to the patient, the patient will mail the prescription to the above address, and the medication will be mailed to the patient within approximately 2 weeks after the pharmacy receives the prescription.
- NOTE: Patients must be enrolled in a Medicare Part D Program. For information or help, patients may call 800-MEDICARE or visit www.medicare.gov.

Reset Form

Please print clearly and complete all blanks

Step 1 - Physician and Prescription Information

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

Product Requested: Once approved for the program the patient will be required to submit a prescription.

Product Name:

Step 2 - 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	US Resident? Yes ☐ No ☐	Do you receive disability benefits? Yes ☐ No ☐	Do you receive VA benefits? Yes ☐ No ☐

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	Medicaid	Medicare Part D
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

CONTINUE TO THE NEXT PAGE

LillyMedicareAnswers Patient Assistance Program

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

Important Instructions: Patients must submit a Low Income Subsidy denial letter if their income is 135% of the Federal Poverty Level or below based on household size. 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.

Step 3-Medicare Part D Prescription Drug Plan Section

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, 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 or for any administrative fee charged under LillyMedicareAnswers; (ii) I have applied for and have formally been denied access to the Medicare Low Income Subsidy or I am ineligible to qualify for the Medicare Low Income Subsidy; and, (iii) I am not eligible for both Medicare and Medicaid. I understand and agree to provide to Eli Lilly and Company ("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 or the LillyMedicareAnswers administrative fee, and I understand that it is my responsibility to notify my Medicare Part D Plan of my enrollment in LillyMedicareAnswers. 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, personal information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the program, 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 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 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 this program. I understand that if my personal 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 personal 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. 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. My adjusted gross income is below 200% of the Federal Poverty Level, as adjusted for the number of persons in my household. (Households with greater than two (2) persons will be assessed per the current year Health and Human Services Poverty Guidelines.)
I understand that the program described herein may be changed or terminated at any time without prior notice.

Patient's Signature:	Date: