Lilly Cares Patient Assistance Program
PO Box 13185
La Jolla, CA 92039
1-800-545-6962 Fax: (844) 431-6650
www.LillyCares.com

Application Form Instructions

The Lilly Cares Foundation, Inc., a private operating foundation, offers the Lilly Cares patient assistance program to help qualifying people get selected Lilly medications.

What products are included?

Group A: For patients who have Medicare Part D **OR** no insurance.

- Cialis® (tadalafil)
- Cymbalta® (duloxetine delayed-release capsules)
- Effient® (prasugrel)
- Evista® (raloxifene hydrochloride)
- Forteo® (teriparatide [rDNA origin] injection)
- Glucagon™ (glucagon for injection[rDNA origin])
- Humalog® (insulin lispro injection)
- Humulin® (human insulin[rDNA origin])
- Prozac® (fluoxetine)
- ReoPro® (abciximab)
- Strattera® (atomoxetine)
- Symbyax® (olanzapine and fluoxetine)
- Trulicity® (dulaglutide)
- Zyprexa®/Zyprexa® Intramuscular/Zyprexa®Relprevv™/Zyprexa®Zydis (olanzapine)

Group B: For patients who have Medicare Part D **OR** no insurance **OR** those whose insurance does not cover the Lilly drug.

- Humatrope® (somatropin [rDNA origin] for injection)

Group C: For patients who have no insurance **OR** those whose insurance does not cover the Lilly drug. Lilly Oncology products provided free of charge through the Lilly PatientOne Patient Assistance Program are provided by the Lilly Cares Foundation, an independent non-profit 501(c)(3) organization that helps eligible patients obtain certain products. PatientOne collects information on behalf of the Lilly Cares foundation for that purpose. For information, call 1-866-472-8663.

Who qualifies for this program?

To qualify, you must meet ALL of the requirements listed below:

- My doctor has prescribed a Lilly drug for me.
- I am a permanent, legal resident of the United States.
- If I am a Medicare Part D patient (except Forteo patients), I have spent $1,100 on medicine this calendar year.
- I am **NOT** enrolled in or eligible for Medicaid or Veteran's Administration Benefits.
- My doctor prescribed a Lilly drug in Group A and I have Medicare Part D **OR** no insurance.
- My doctor prescribed a Lilly drug in Group B and I have Medicare Part D **OR** no insurance **OR** my insurance does not cover the Lilly drug.
- **Humatrope Patients** - Must have a "No Funding Letter" from Humatrope Direct Connect which states that I have no other way to pay for my Humatrope therapy. Contact Humatrope Direct Connect at 1-84Humatrope (1-844-862-8767) if you need this letter. Medicaid or Veteran's Administration Benefits may qualify.

If you have questions about qualifying and applying, please call us at 1-800-545-6962.

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Application Form Instructions - Continued

Who qualifies for this program? - Continued

- My household income is under the Annual Income Limit listed below:

Number of Persons in Your Household	Annual Income Limit *If you live in Alaska, Hawaii, or D.C., please contact us for adjusted Annual Income Limits	
	Group A Products	**Group B Products**
1	$35,640	$59,400
2	$48,060	$80,100
3	$60,480	$100,800
4	$72,900	$121,500
5	$85,320	$142,200
6	$97,740	$162,900

***Note**: These income limits are 300% and 500% of 2016 Federal Poverty Guidelines. You may also visit www.aspe.hhs.gov/poverty for information on Federal/Poverty Level. Federal Poverty Guidelines may change yearly.

How do I apply?

To apply, complete the following 4 steps:

1. Complete and return the Patient Section (page 4) and **sign** the Patient Certification (pages 5-6).
2. Have your doctor complete and return the Doctor Section, **sign** the Doctor Confirmations and Agreements, and send a prescription for your medicine (page 7).
3. If you have Medicare, attach a copy of the **front** of your Medicare Part D card. Attach a copy of your Low Income Subsidy denial or rejection letter if this applies to you.
4. Select and copy appropriate proof-of-income documents. Keep copies for your records.
5. Fax or mail the application form, prescription, copies of proof-of-income and copy of Medicare Part D card (if this applies to you) to Lilly Cares. Mailing address and fax number are at the top of this page.

What happens next?

When we receive your application, we will review it to see if you qualify for Lilly Cares.

- **If you are a Medicare Part D patient:**
  1. You will be enrolled until the end of the calendar year and must apply again upon reaching your out-of-pocket pharmacy spend (except Forteo) for the next calendar year.
  2. You will pick up your medication from your doctor in 3-4 weeks. Forteo and Humatrope generally require home delivery due to medication handling. Patient will be contacted to schedule home delivery starting May, 2016.
- **If you are under the age of 65 and NOT a Medicare Part D patient:**
  1. You will be enrolled for 12 months. After 12 months, you must apply again.
  2. You will pick up your medication from your doctor in 3-4 weeks. Forteo and Humatrope generally require home delivery due to medication handling. Patient will be contacted to schedule home delivery starting May 2016.
- **If you do NOT qualify, we will send a notice to you and your doctor.**

If you have questions about qualifying and applying, please call us at 1-800-545-6962.

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Patient Section

Patient Name:(Last)______________________________(First)_____________________(MI)______

Address:____

City:___________________________State:________Zip_________Date of Birth:____/____/______
Month Day Year

Home Phone (____) _____-_________ Cell Phone (____) _____-___________

Patient Income Information

Number of family members living in your household: ____________________
Total Gross Household Income (before deductions): ___________________________/yearly

1. **Proof of income—send copies only, no originals**

Send at least 1 document that shows that you have a low income, or no income—such as documents listed below:

- Copy of last year's Federal Income Tax Return
- Copy of current pay stubs or earnings statements
- Copy of Social Security Income Yearly Benefit Statement
- Copy of W-2 or 1099 Form
- Copy of Unemployment Benefit Statement
- Copy of Statements of interest, dividends, or other income

2. **Additional Proof of Pharmacy Spend Required for Medicare Patients (except Forteo patients):**

Send proof that you have spent $1,100 (except Forteo) on medicine this year. This can be an explanation of benefits or summary from your pharmacy where you get your medications filled.

Text Message –

If your application is **approved** we can send you a text message. The text message is optional. You can participate in Lilly Cares without signing up for the text message.

When you sign up for the text message, you must agree to the following conditions:

- Lilly will send only one message. It will be an autodialed, pre-recorded message. (Standard text message and data rates apply.)
- Be aware that anyone who can open your phone might see your text message.
- The text message is **NOT** a reminder. You are responsible for taking your medication as prescribed.
- Do **NOT** report product complaints or adverse events (like side effects) by text message. To report these; please call the Lilly Answers Center at 1-800-LillyRx (1-800-545-5979).

To receive a text message, you must provide your Cell Phone Number ____________________

If you do not know which documents to send, you can call Lilly Cares at 1-800-545-6962.

Please read and continue on page 5:

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Patient Certification (Agreement)

I certify (agree) that the following statements are true:

- I am a legal, permanent resident of the United States.
- I am **NOT** enrolled in or eligible for Medicaid or Veteran's Administration. Humatrope patients may be eligible.
- If I am a Medicare patient (except Forteo patients), I have spent $1,100 on medications this year.
- My doctor prescribed a Lilly drug in Group A and I have Medicare Part D **OR** no insurance.
- My doctor prescribed a Lilly drug in Group B and I have Medicare Part D **OR** no insurance **OR** my insurance does not cover the Lilly drug.

I consent to the sharing, use, and receipt of information about me, as described below:

To run Lilly Cares, Lilly needs some information about you. When you sign below, you understand and you are authorizing Lilly to share, use and disclose your information, and you are authorizing any pharmacy and or health care provider who is in possession of your health information to share with Lilly information about you, including health information, that will be used to operate and administer the Lilly Cares Program, as stated below. "Lilly" refers to Lilly, Lilly Cares, and its vendors and business partners contracted to be the Program administrator of Lilly Cares.

Lilly may receive, share, and use the following information:

- Information in this application.
- Information about my medical conditions, treatment, current and future medicines, and insurance information.
- Other information Lilly may obtain to operate the Lilly Cares Program.
- Lilly may share my information with my health care providers and pharmacists.
- My health care providers and pharmacists may share my information with Lilly.
- Lilly may share my information with the Centers for Medicare and Medicaid Services ("CMS") and/or my Medicare Part D Plan Administrator. This will be consistent with the terms of any Data Sharing Agreement agreed upon by Lilly and CMS or my Medicare Part D Plan.

Lilly may share my information for the following purposes:

- To review my application and to contact me or my health care provider, if necessary, for that review.
- To help operate the Lilly Cares Program and Lilly's internal purposes involving other patient assistance and charitable programs.
- To my pharmacies and health care providers relating to my participation in Lilly Cares, including personal information and information about my prescription drugs.

If you do not know which documents to send, you can call Lilly Cares at 1-800-545-6962.

Please read and sign the next page:

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Patient Certification (Agreement) - Continued

By my signature below, I also agree to the following:

- If I am **NOT** a Medicare Part D patient, I understand that my authorization to release my Protected Health Information (PHI) enables a health care provider relying on this authorization to release my PHI to Lilly for one year from the date it is signed, and then I need to apply again to Lilly Cares.
- If I am a Medicare Part D participant, I understand that my authorization to release my PHI enables a health care provider relying on this authorization to release my PHI to Lilly for the remainder of this calendar year that it is signed, and then I need to apply again to Lilly Cares.
- I understand that if my information is shared in this manner, federal and state privacy laws may no longer protect my PHI and may not prohibit its further disclosure; however, Lilly has committed to use and disclose my PHI only as stated in this form.
- I understand if I do not sign or refuse to sign this form, I will not be eligible for Lilly Cares.
- I understand that I can cancel my consent any time by sending a written notice to Lilly Cares at the address on this application. If I cancel my consent, I will no longer qualify for Lilly Cares. My health care providers will no longer share my PHI with Lilly after the date that Lilly receives and processes my cancellation letter, but this will not affect information or disclosures shared before that time. Additionally, once my cancellation is received and processed by Lilly, my participation in the program will be terminated and after my participation is terminated, Lilly will only maintain and use my information for legal and regulatory purposes.
- I agree to follow the rules and conditions of the Lilly Cares Program.
- I have been provided a copy of this authorization.
- I understand that Lilly Cares will decide if I qualify for this program. I understand that my application might not be approved.
- I will not submit any claim for reimbursement to any third party insurer for any product provided to me under the Lilly Cares Program.
- If I am in Medicare, I will not claim any true-out-of-pocket-cost (“TROOP”) from my Medicare Part D Plan for the value of the product given to me under Lilly Cares.
- If I am in Medicare, I understand that it is my responsibility to let my Medicare Part D Plan know about my enrollment in the Lilly Cares Program.
- I understand the Lilly Cares Program may change or end at any time without advance notice.
- I understand and agree that if Lilly asks, I will provide documentation that proves the information I have certified in this application is true, correct, and complete.
- **I understand that the Lilly Cares Foundation 501(c)(3) does not charge a fee for participation in the Lilly Cares program. Lilly is not affiliated with third parties who charge a fee for help with enrollment or medication refills. I am not required to use a third party who charges a fee to help with my enrollment, and if I use a third party who charges a fee to help with my enrollment or refills of my medicine, this money is not paid to the Lilly Cares Foundation 501(c)(3).**

Patient or Legal Guardian Signature:______________________________**Date:** _____________

Signature Required

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Doctor Section

Name of doctor/prescriber:____(circle: M.D. D.O. N.P. P.A.)

Mailing Address:____

City:___________________State:_______Zip:_____________ Suite Number: ___________

Shipping Address for medications:____

City:___________________State:_______Zip:_____________ Suite Number: ___________
(**Note**: We must ship medication to the prescribing provider. We cannot ship to a PO Box.)

Phone: (_______)_______-_______________ Fax: (_______)_______-_______________
State License #______________________________________ Expiration Date: _____________________
DEA #____ Expiration Date: _____________________
(Only for requests of controlled substances)

Prescription and Refill Information: **Completion of this section is OPTIONAL for the Doctor/Prescriber, PROVIDED an actual prescription is submitted with the application. Forteo and Humatrope REQUIRE an actual prescription, with the doctor/prescriber signature.**

Patient Name: ____

Product Requested: ____

Dosage:___________________________ (If prescribing insulin indicate max number of units/day)

Sig:____Quantity:____________________

Medication orders may be written for up to a 1-year supply, subject to program eligibility limits. Up to a 120- day supply is available in each shipment, unless a lesser amount is prescribed or provided per program guidelines. Refills: Lilly Cares Fax Refill form is located on our web site at www.LillyCares.com or can be placed by calling 1-800-545-6962. If the prescription is as listed on the original approved application, the refill request will be processed. If any part of the prescription has changed, a completed refill form will be required.

Doctor/Prescriber's Confirmations and Agreements:

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 "health care provider") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients").

By signing below, I (the Prescriber) agree to the following terms and conditions:

- I will accept the Medication from Lilly Cares (except Forteo and Humatrope which may be dispensed to the patient home) and deliver the Medication only to the qualifying Patient named on this form at no charge of any kind. I will not use any of the Medication for any other purpose. This Medication will not be offered for sale, trade, or barter.
- I have made my patient aware that I am releasing their personal health information to Lilly Cares for treatment purposes.
- I will give Lilly Cares 90 days advance notice if I need to assign this agreement, in full or in part, to another Prescriber.
- I am licensed to practice and dispense medicine and will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above Patient.
- Lilly Cares has the right to contact the Patient directly to make sure that the Medication was received.
- Lilly Cares has the right to revise or terminate the Program at any time.
- All the Lilly Cares Medications I have ever received and distributed were distributed only to Qualifying Patients.
- I agree to properly dispose of unused Medication.

My signature below attests to my understanding and agreement to the above program requirements.

Prescriber Signature:____ Date:____________________
Original Signature Only; No Photocopies or Stamps

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