The Lilly Cares Foundation, Inc. ("Lilly Cares"), a nonprofit organization, offers a patient assistance program to assist qualifying patients in obtaining certain Lilly medications at no cost.

This enrollment form is for patients who have been prescribed one of the following Lilly medications and would like to apply to receive the medication free of charge from Lilly Cares if they qualify:

- Alimta® (pemetrexed for injection)
- Cyramza® (ramucirumab)
- Erbitux® (cetuximab)
- Lartruvo™ (olaratumab)
- Portrazza® (necitumumab)
- Verzenio™ (abemaciclib)

To qualify, patients must meet ALL the requirements listed below:

✓ You have been prescribed a Lilly Oncology medication listed above.

✓ You are a permanent legal resident of the United States or Puerto Rico.

✓ You have no insurance **OR** your insurance does not cover the prescribed Lilly oncology medication. If you have insurance that does not cover the medication, you must submit documentation that the insurance has denied the initial claim and denied two appeals. Your healthcare provider (HCP) or specialty pharmacy may be able to assist you with obtaining this documentation. If your HCP or specialty pharmacy needs assistance with obtaining the documentation they may contact one of the following Lilly sponsored customer support programs:

—For infused medications, call Lilly PatientOne by dialing 1-866-4PatOne (1-866-472-8663)

—For Verzenio, call Verzenio Continuous Care by dialing 1-844-VERZENIO (1-844-837-9364)

✓ For Verzenio only, you have enrolled in a Medicare Part D plan if you are eligible for Medicare.

✓ You have been prescribed a Lilly oncology medication for an FDA-approved indication and/or compendia use.

✓ The treatment must be provided in an outpatient setting.

✓ For infused medications, you must have received treatment within 180 days of application approval.

✓ Your Annual Adjusted Gross Household Income must be at or below 500% of the Federal Poverty Guidelines. Visit (https://aspe.hhs.gov/poverty-guidelines) for information on the Federal Poverty Guidelines. (Please see table below)

Number of Persons in your Household	Annual Adjusted Gross Income Limit If you live in Alaska or Hawaii, please contact us for annual adjusted gross income limits	Number of Persons in your Household	Annual Adjusted Gross Income Limit If you live in Alaska or Hawaii, please contact us for annual adjusted gross income limits
1	$60,700	5	$147,100
2	$82,300	6	$168,700
3	$103,900	7	$190,300
4	$125,500	8	$211,900

Completing this form is the first step in the application process. Lilly Cares may need additional information to make sure a patient is eligible.

Application Form Instructions

Step 1—Complete the Application

- Complete the whole application, including the Patient Section on pages 3-4 and the Healthcare Provider/Prescriber section on pages 5-6.

Step 2—Include All the Attachments

- Be sure to include the appropriate income documentation.
- If you are applying for Verzenio and have Medicare Part D, attach a copy of the front of your Medicare Part D card.
- Some people with limited income (approximately less than $16,389 individual, or less than $22,221 married couple living together) may be able to get Extra Help, known as Low Income Subsidy (LIS), to assist with costs related to a Medicare prescription drug plan. For assistance in determining if you qualify for LIS, please call the Social Security Administration at 1-800-772-1213. If your gross income is equal to or less than the income described, please submit a copy of a Low Income Subsidy (LIS) denial letter. Medicare Part D patients who qualify for full LIS are not eligible for Lilly Cares.

Step 3—Sign The Application

- The Patient must sign the Patient Agreement and Consent.
- The Prescriber must manually sign the Physician Acknowledgment. We cannot accept signatures from anyone else or rubber stamps.

Step 4—Fax the Application

- Fax the completed application and any supporting documents to Lilly Cares at 1-888-242-6230. We recommend that you return the completed form by fax in order to speed up the process.
- Incomplete or incorrect information will delay the process, so please make sure all information is provided correctly and signatures are obtained.
- If you have any questions, please call Lilly Cares at 1-800-545-6962.

Patient Section

All fields are required. Please print.

Patient Name: (Last, First, MI)					
Address:					
City:		**State:**		**Zip:**	
Date of Birth: Month/Day/Year		**Social Security Number for income verification:**			
Home Phone: xxx-xxx-xxxx		**Cell Phone: xxx-xxx-xxxx**			

Patient Insurance and Income Information

Adjusted Gross Yearly Household Income		**Number of People in Household**	

Please submit at least one copy showing your proof of income with this application. Examples of acceptable documents include, but are not limited to:

- Copy of unemployment benefit statement
- Copy of W-2 or 1099 Form
- Copy of Social Security Income yearly benefit statement
- Copy of current pay stubs or earnings statements
- Copy of statements of interest, dividends, or other income

Insurance Information

Do you have insurance? (check all that apply)		
☐ **Medicaid**	☐ **Medicare A or B**	☐ **Medicare Part D**
☐ **VA or Military**	☐ **Private Insurance**	☐ **None**
Other:		

Optional Text Message Notification of Approval for Verzenio

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 Cares will send only one message. It will be an autodialed, pre-recorded message. (Standard text message and data rates apply.)
- You can opt out at any time by calling 1-800-545-6962.
- Be aware that anyone who can open your phone might see your text message.
- The text message is NOT a reminder to take your medication. You are responsible to take 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: _____

Optional Authorization to Speak with Authorized Representative

If you would like to provide the name(s) of an individual(s) whom you authorize to speak with Lilly Cares Program Representatives (defined below) on your behalf about this application or your participation in the Lilly Cares program, please identify the individual(s) below.
An authorized representative has the authority to interact with Program Representatives on an applicant's behalf with respect to the Lilly Cares application and program, and can provide or receive personal information about the applicant as necessary until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

By providing the name(s) below, I certify that the individual(s) is aware and has consented to my disclosure of their name to Program Representatives for the purpose of serving as my authorized representative.
1. Name of Authorized Representative: _____
2. Name of Authorized Representative: _____

You can remove Authorized Representative(s) at any time by calling 1-800-545-6962.

Patient Agreement and Consent

PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL Lilly Cares at 1-800-545-6962. YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.

- The Lilly Cares Foundation, Inc. ("Lilly Cares"), is a non-profit organization that offers a patient assistance program to help qualifying patients obtain certain Lilly medications at no cost.
- I understand that I or my doctor's office is submitting this application to see if I qualify for assistance with my Lilly oncology medications through Lilly Cares. I understand that before Lilly Cares can assist me, Lilly Cares may need to collect, use, and share information about me. This information is requested in this application. This information is called My Personal Information. It includes the following:
  - My Protected Health Information ("PHI")
  - My financial information
  - Other personal information about me
- My PHI may include:
  - Any information related to my healthcare insurance or plan benefits, including coverage limits.
  - Other information related to my health and treatment. This may include information that may be sensitive, relating to sexually transmitted diseases, mental health conditions, and/or genetic testing.
  - Information related to my health while I am in the Lilly Cares program, such as whether I'm staying on my medicine or treatment.
  - Some information that may not be related to my Lilly oncology medication and is not requested by Lilly Cares. This information may be sent only because it is part of my health care records.
- I understand that by signing this form, I am permitting the following providers to release My Personal Information, including my Protected Health Information, to Lilly Cares Program Representatives (defined below):
  - My doctor's office
  - My healthcare plan or insurance company
  - My pharmacies
  - Other providers
- Lilly Cares "Program Representatives" include the Lilly Cares Foundation, Inc., Eli Lilly and Company, Lilly USA, LLC, and their vendors, business partners, and agents who may be assisting Lilly Cares. I understand that to provide the services for Lilly Cares, the Program Representatives may need to share My Personal Information with other Program Representatives involved with Lilly Cares, and with my doctor's office or other healthcare providers, including my insurance company or health plan or pharmacies.
- I attest that I am a permanent, legal resident of the US or Puerto Rico.
- I further understand that the Program Representatives will use My Personal Information in the following manner:
  - To review my application for the Lilly Cares program.
  - To contact me or my doctor's office or other of my healthcare providers, as necessary, to conduct such services.
  - For purposes relating to the operation and administration of the Lilly Cares program, including measuring and tracking the quality of the services.
  - To keep track of my use of Lilly oncology medicines provided by Lilly Cares.
- I also understand that the Program Representatives can contact me to collect any additional information needed to provide these services to me.
- I understand if I do not sign or refuse to sign this form, I will not be eligible for Lilly Cares.
- This authorization allows those who rely on it to release my PHI for 1 year from the date I have signed it. I understand that I can withdraw it at any time by sending a written notice to Lilly Cares at PO Box 13185 La Jolla, CA 92039. My withdrawal goes into effect once it is received by Lilly Cares. I also understand that by withdrawing, I may not receive or I may stop receiving Lilly oncology medicines provided by Lilly Cares.
- I authorize the Lilly Cares Program Representatives to obtain a consumer report about me in conjunction with my application. Lilly Cares may use my name, date of birth, address, and social security number to obtain my consumer report including, but not limited to, information regarding my household size and income. My consumer report will be used to estimate my household income as part of the process to decide if I am eligible to receive free medication from Lilly Cares. This soft credit inquiry will not impact my credit score. Upon request, Lilly Cares will provide me the name and address of the consumer reporting agency that provides the credit information. I may call Lilly Cares at 1-800-545-6962 for this information.

☐ **I have read and understand**

X		Date	
	Patient or Legal Guardian Signature		
X			
	Printed Name of Patient or Legal Guardian		

Healthcare Provider/Prescriber Information

Facility Name		**Facility NPI**			
Healthcare Provider/ Prescriber Name					
Healthcare Provider/ Prescriber State License					
Address:					
City:		**State:**		**Zip:**	
Office Contact		**Office Phone:**			
Phone Ext		**Fax**			

Prescription/Medication Order Information

Complete this section for infused medications

Treatment Setting

❑ **Healthcare Provider/ Prescriber's Office** ❑ **Hospital Outpatient**

Name and Address of Treatment Facility	

❑ **Product Replacement–Request product after dose has been administered** ❑ **Proactive Provision–Request product prior to administration**

Date				**ICD.10**	
Patient Name				**DOB**	
Patient Address				**Patient Phone**	
City:		**State:**		**Zip:**	
Product Requested	☐ **Alimta** ☐ **Erbitux** ☐ **Portrazza** ☐ **Cyramza** ☐ **Lartruvo**			**Vial Size/ Strength**	
Sig				**# of Vials**	
Scheduled Administration Dates				**Dosing Schedule/ Frequency**	

Complete this section for Verzenio

Date:				**ICD.10:**	
Patient Name:				**DOB:**	
Patient Address				**Patient Phone**	
City:		**State:**		**Zip:**	

Prescription for Verzenio™ (abemaciclib) tablets

☐ **Verzenio 200 mg 7-day blister pack** (NDC: 0002-6216-54)
Sig/Directions: 200 mg (1 tablet) twice daily

☐ **Verzenio 150 mg 7-day blister pack** (NDC: 0002-5337-54)
Sig/Directions: 150 mg (1 tablet) twice daily

☐ **Verzenio 100 mg 7-day blister pack** (NDC: 0002-4815-54)
Sig/Directions: 100 mg (1 tablet) twice daily

☐ **Verzenio 50 mg 7-day blister pack** (NDC: 0002-4483-54)
Sig/Directions: 50 mg (1 tablet) twice daily

Quantity (up to 2-month supply):_____ **Refills (up to 1 year):**_____

Prescriber Signature (no stamps): I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize the Lilly Cares Program Representatives to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy, if applicable. Your state may require that prescriptions follow certain content requirements or use a particular form. By signing below you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the state in which you are prescribing.

X	X
Dispense as Written	May Substitute

Healthcare Provider/ Prescriber Acknowledgment

By signing the below, I certify:

- The information provided is accurate to the best of my knowledge
- The therapy is medically necessary. I also represent that I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient, the Lilly Cares Foundation, Inc., Eli Lilly and Company, Lilly USA, LLC and their vendors, business partners, and agents (the "Program Representatives") for the purpose of assessing whether the patient qualifies for the Lilly Cares program through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Program Representatives so that Program Representatives may contact the patient to further enable these services
- I am licensed, 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 the medication identified on this application to the patient listed in this application. I prescribed the medication to this patient based on my independent clinical judgment that treatment with this medicine for this patient is medically necessary
- I have prescribed this patient a Lilly oncology medication for an FDA-approved indication and/or compendia use
- To the best of my knowledge the patient meets the financial, insurance, and residency requirements of the Lilly Cares program. If I am aware the patient no longer meets the criteria for the program, I agree to immediately notify Lilly Cares
- I have not received and will not seek reimbursement or payment for all or any part of the benefit received by the patient through Lilly Cares
- Any medication provided by Lilly Cares for this patient will not be resold, nor offered for sale, trade or barter, or returned for credit
- The payer's required number/level of appeals have been completed and I have received denials on each of those appeals

I understand:

- Lilly Cares may change, terminate, suspend participation, limit enrollment, or recall/discontinue medications in the program without prior notice
- I am under no obligation to purchase or prescribe any Lilly drug to participate in this program and I have not received nor will I receive any benefit from any Program Representatives for prescribing a Lilly drug
- Program Representatives are not responsible for filing any insurance claim
- The information provided will be subject to potential random reviews
- If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Lilly Cares will bill for the covered product, and I agree to be responsible for payment of the bill
- If I elect to receive medication from Lilly Cares under the Proactive Provision program, I certify that I will complete the required Administration Verification form confirming that the product has been administered to the applicable enrolled patient. I will notify Lilly Cares if any product is not administered to the applicable enrolled patient and will return the product to Lilly Cares for destruction or appropriately destroy the product at the facility and submit documentation to Lilly Cares confirming that the product has been appropriately destroyed. If I do not return or destroy the product provided and not used for the applicable enrolled patient, I will be billed for the product and I agree to be responsible for payment of the bill. Please contact Lilly Cares at 1-800-545-6962 for assistance with product returns.

Patient Name		DOB	

X		Date	

Healthcare Provider/ Prescriber Signature (no stamps)