

**Lilly Cares Foundation Patient Assistance Program**

PO Box 13185  
La Jolla, CA 92039  
Phone: 1-800-545-6962  
Fax: 1-844-431-6650  
www.LillyCares.com



**Lilly Cares Prescription FAX Form Olumiant®**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

**Rx:** I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy.

Please indicate patient's treatment plan:

**Olumiant® (baricitinib) 2 mg tablet by mouth once daily**

Quantity to be Dispensed:  120 tablets (max)  90 tablets  60 tablets  30 tablets

Refills: # \_\_\_\_\_ (up to one year of treatment) **Date:** \_\_\_\_\_

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 states in which you are prescribing.

Signature: \_\_\_\_\_  
**Dispense as written** **Substitution/brand exchange permitted**

Supervising Physician Signature and Date (where required): \_\_\_\_\_

*Rubber stamps, signature by other office personnel for the prescriber and computer-generated signatures will not be accepted.*

Printed Prescriber Name and Title: \_\_\_\_\_ FAX: \_\_\_\_\_

State License Number and State: \_\_\_\_\_ Phone: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

**IMPORTANT:** This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

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