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: _____