Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

ThrIVewell
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

KISUNLA™ (donanemab-azbt) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Phone:	Preferred Location:	

PROVIDER INFORMATION

Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Office Contact:	Address:
Email (required):	

REFERRAL STATUS

Check One: ☐New Referral ☐Referral Renewal ☐Updated Order ☐Transfer of care – Date of last infusion/Next due date

KISUNLA:
Kisunla is indicated for the treatment of Alzheimer's disease (AD). Treatment with Kisunla should be initiated in patients with mild cognitive impairment (MCI) or mild dementia stage of disease, the population in which treatment was initiated in the clinical trials.

■ **Diagnosis ICD-10**
Check one:
- ☐ G31.84 Mild Cognitive impairment, so stated
- ☐ G30.0 Alzheimer's Disease with early onset
- ☐ G30.1 Alzheimer's Disease with late onset
- ☐ G30.8 Other Alzheimer's Disease
- ☐ G30.9 Alzheimer's Disease, unspecified

■ **Premeds**
Select all that apply:
- ☐ Acetaminophen _____mg PO (recommended for first 6 doses)
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine (check all that apply)
  ___25mg ___50mg ___PO ___IV
- ☐ Methylprednisolone _____mg IV
- ☐ SoluCortef _____mg IV
- ☐ Other: _____

PATIENT WEIGHT
_____ lbs.
_____ kg

Therapy Administration and Dosing (supplied as 350mg/20mL vial)
All doses will be administered via appropriate final concentration of 4mg/mL to 10mg/mL

- ☐ Doses #1 – 350mg IV – Administer in 0.9%NS IVPB over at least 30 minutes
- ☐ Doses #2 – 700mg IV – Administer in 0.9%NS IVPB over at least 30 minutes
- ☐ Doses #3 – 1050mg IV – Administer in 0.9%NS IVPB over at least 30 minutes
- ☐ Doses #4-18 – 1400mg IV – Administer in 0.9%NS IVPB over at least 30 minutes

REQUIRED CLINICAL DOCUMENTATION CHECKLIST:

- _____ Demographics page with insurance info
- _____ Progress note with cognitive testing within the last 6 months
- _____ Patient's recent weight
- _____ Amyloid PET scan or CSF results with amyloid confirmation
- _____ MRI of the brain within the last year
- _____ If Medicare patient, Alzheimer's Registry number (i.e. ALZH-00000)

Please indicate here any preferred variation from standard orders including longer infusion times, less doses, etc.: _____

- All patients will be kept for 30 minutes of monitoring following completion of infusion per the guidelines in the PI.
- Please note MRIs to assess for ARIA are required prior to doses 2, 3, 4 and 7 and must be sent to Thrivewell in order for patient to be cleared to proceed with treatment. Failure to provide the required MRI report at least 24hrs prior to the patient's scheduled appointment may result in delay in care for the patient.

Additional Orders: By signing this order, you agree to the following orders unless otherwise noted.
- Hold infusion and notify provider if patient reports: Headache, dizziness,nausea, vision changes, new or worsening confusion, balance concerns, or change in mentation.
- Infusion/allergic reactions may be managed by clinical staff per facility protocol. Provider office will be notified in real time of any infusion reactions.

Provider Signature:_____ **Date:**_____

Notes/Additional Comments: _____

Lilly Support Services™

PATIENT ENROLLMENT SECTION

Kisunla™ (donanemab-azbt)
injection for IV infusion

PUBLISHED 07/2025

OFFICE: Complete the entire form and submit pages 1-5 to Lilly Support Services™ via fax at 1-844-731-2697 or complete online at https://enroll.lillysupportservices.lilly.com. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Items with † on pages 1-5 are required to complete enrollment.

Section 1: Patient and Alternate Contact Information

Patient Name† (First, MI, Last) _____ **DOB†** (MM/DD/YYYY) _____

Address† _____ **City†** _____ **State†** _____ **Zip†** _____

US or Puerto Rico Resident† ☐ Yes ☐ No **Gender** ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone†* _____ **Email** _____

☐ *By checking the box, I agree to receive automated marketing calls and texts from and on behalf of Eli Lilly and Company. I understand that I am not required to provide my number as a condition of receiving goods and services. Message and data rates may apply.

☐ By checking the box, I agree to be contacted to: provide feedback on my experience with the related products, services, and programs; to share my story; and, to participate in market and medical research studies about products and services.

You may provide the name of an Alternate Contact with whom you authorize Lilly Support Services™ to speak on your behalf about your participation in this program. This person can provide or receive your personal information as necessary until you terminate their authority. By providing the information below, you certify that the individual is aware and agrees that you will provide their name and contact information to Lilly Support Services™ for the purpose of serving as an Alternate Contact. You can change or remove the Alternate Contact at any time by calling Lilly Support Services™ at 1-800-LillyRx (1-800-545-5979).

Alternate Contact (First, Last) _____ **Relationship to Patient** _____

Alternate Contact Phone _____ **Alternate Contact Email** _____

If an Alternate Contact is listed in this section, the Primary Contact should be (select one): ☐ **Patient** ☐ **Alternate Contact**

Primary Contact Communication Preferences: Method ☐ Phone Call ☐ Text ☐ Email **Best Time To Call** ☐ Morning ☐ Afternoon ☐ Evening

Section 2: Primary Insurance Information

Must select one of the following:
☐ **No Insurance Coverage**
☐ **Copy of Policyholder's Insurance Card (front and back) is Attached**
☐ **Provide Information Below (If checked, information below is required†)**

Must select your type of insurance: ☐ **Medicare** ☐ **Medicaid** ☐ **Commercial** ☐ **Other** _____

Primary Medical Insurance Company/Provider _____

Insurance Company Phone # _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

Section 3: Secondary Insurance Information

Must select one of the following:
☐ **No Secondary Insurance Coverage (Proceed to the next section)**
☐ **Copy of Policyholder's Insurance Card (front and back) is Attached**
☐ **Provide Information Below (If checked, information below is required†)**

Must select your type of insurance: ☐ **Medicare** ☐ **Medicaid** ☐ **Commercial** ☐ **Other** _____

Secondary Medical Insurance Company/Provider _____

Insurance Company Phone # _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

Section 4: Terms of Participation and Program Disclosures

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using Kisunla™, an Eli Lilly and Company medicine. Lilly Support Services™ for Kisunla™ offers personalized support to Patients at no charge and was created to help you have a positive experience as you get started with and use this medicine.
By signing and submitting this form, you consent to your enrollment into Lilly Support Services™. As part of your participation in Lilly Support Services™, you understand and authorize Lilly USA, LLC to retain and use your personal information for the purposes described in this form. Eli Lilly and Company, Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "Lilly") may use, disclose, and/or transfer the personal information you supply to provide services related to your condition and treatment to administer the program. The Lilly Support Services™ Support team can contact you by email, mail or telephone to provide personalized services and information and materials directly related to your condition and therapy; responding to customer service requests and/or questions about your treatment; disclosing your enrollments and use of these services to your doctors and insurers; analyzing and/or measuring program performance and program effectiveness for future enhancements; and other activities related to your condition and therapy that are part of Lilly Support Services™. Your personal information, including information that may be related to your health, is needed to fulfill your request. To cancel your participation in the program, please contact us at 1-800-LillyRx (1-800-545-5979) Mon - Fri, 9am - 6pm ET.
For information about Lilly's privacy practices, please see our Privacy Statement at https://privacynotice.lilly.com and the Consumer Health Privacy Notice at https://www.lillyhub.com/legal/lillyusa/CHPN.html.

Please continue to the next page.

Lilly A MEDICINE COMPANY

Lilly Support Services™

HIPAA AUTHORIZATION

OFFICE: Complete the entire form and submit pages 1-5 to Lilly Support Services™ via fax at 1-844-731-2697 or complete online at https://enroll.lillysupportservices.lilly.com. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

PUBLISHED 07/2025

You have selected Eli Lilly and Company ("Lilly") to coordinate certain services related to your health and to provide information related to your health (Lilly's "Programs and Services"). In order for Lilly to offer the Programs and Services, Lilly may need to obtain or exchange your protected health information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") from your Health Care Entities (as defined below). PHI can be inclusive of "sensitive data" as defined by applicable U.S. privacy laws. After your PHI has been released to Lilly, it is no longer covered by HIPAA. By signing this form, you understand and authorize your Health Care Entities to share your PHI with Lilly and use as explained below.

PHI includes the following individually identifiable information:

- Information about your health insurance or benefits, including how much coverage you have
- All relevant records about your treatment, including medication histories and prescriptions
- Information about your payment for treatment, including any insurance coverage
- Whether you're staying on your medicine or treatment

If you agree, your PHI may be collected from and shared by these entities (together "Health Care Entities"):

- Your doctors and other healthcare providers
- Your healthcare plan or health insurance company
- Clearinghouses or other agents
- Your pharmacy
- Others who might have your PHI on behalf of your healthcare providers, pharmacies and healthcare plans

How Your PHI Will Be Used

Your PHI will be used to enroll you in, provide you with, and operate and administer the Programs and Services, consistent with Lilly's Privacy Statement and Consumer Health Privacy Notice, including to:

- understand how much of your Lilly treatment is covered by your insurance
- help you find ways to afford such treatment
- track the shipment, receipt, and use of your Lilly treatment and Programs and Services
- share information with your Health Care Entities and communicate with them regarding Lilly Programs and Services
- contact you about Lilly Programs and Services related to your health needs
- measure Lilly Programs and Services' performance in order to make improvements and drive business decisions and metrics
- de-identify your data for analytics including reports about Health Care Entities' use of Lilly Programs and Services.

Please continue to the next page.

Lilly A MEDICINE COMPANY

PUBLISHED 07/2025

Other things you should know about how we may use and share your PHI:

We do not ask for any PHI that we do not need, but we may receive some in the health records sent to us. Your PHI will be released to Lilly and its wholly owned subsidiaries ("Lilly" or "we") and/or entities or persons that work on behalf of, or in partnership with, Lilly but are not Lilly employees ("Third Parties").

- You don't have to give permission to share your PHI with Lilly to receive treatment from your Health Care Entities, your prescription from your pharmacy, or benefits from your healthcare plan, but Lilly Programs and Services may not be able to help you without your Authorization.
- Your Health Care Entities may receive compensation from us in exchange for sharing your PHI. They may also be paid by us to use your PHI to provide services, such as contacting you about Lilly products.
- Your signed authorization to share and use your PHI lasts for the duration of your participation in Lilly Programs and Services from the date of your signature or earlier as required by state law. In any case, you may revoke this Authorization for Lilly Programs and Services and you may request to obtain PHI from your Health Care Entities at any time by writing to 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067. Your revocation of this Authorization will not have any effect on any uses or disclosures of your PHI that occurred prior to Lilly's receipt of your revocation.
- **Your revocation of this Authorization will be effective when your Health Care Entities receive notice of your cancellation or revocation and will not apply to any information shared with Lilly prior to receipt of the notice.**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my Health Care Entities to disclose my PHI and sensitive data for the purposes as described in this HIPAA Authorization. This HIPAA Authorization replaces any prior HIPAA Authorizations that I may have provided at a specific program level.

By signing this form, I attest that I have read and agree to the Patient HIPAA Authorization. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient† _____

Not signing this form will result in an incomplete submission and a delay in requested services

Printed Name of Patient _____

Date Signed† (MM/DD/YYYY) _____

DOB (MM/DD/YYYY) _____

Lilly Support Services™

PRESCRIBER ENROLLMENT SECTION

Kisunla™ (donanemab-azbt)
injection for IV infusion

PUBLISHED 07/2025

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Section 5: Prescriber Information

Prescriber Name† (First, Last) _____ **NPI #**† _____

PTAN #† _____ **Tax ID #**† _____ **Phone**† _____ **Fax**† _____

Address† _____ **City**† _____ **State**† _____ **Zip**† _____

Office Contact Name _____ **Office Contact Phone** _____

Office Contact Email _____

Collaborating Physician _____ **NPI #** _____ **Group Tax ID** _____

Section 6: Service Selection

DESCRIPTION OF AVAILABLE SERVICES

Benefits Investigation: Researches the Patient's insurance to help identify the lowest out-of-pocket cost available for Kisunla™.

Care Coordination: Optional service that coordinates reimbursement and adherence requirements (such as MRIs or other medical documentation) across a Patient's Kisunla™ treatment team. If selected, Lilly Support Services™ will request the HCP to routinely submit information via our Care Coordination Form. Care Coordination also includes outreach to the Site of Care (HCP Office or Infusion Center) to collect infusion appointment dates.

Infusion Center Locator Support: Helps your Patient locate a convenient infusion site to receive their Kisunla™ treatment.

Nurse Navigators: Service included for all Patients enrolled in Lilly Support Services™ for Kisunla™. Nurses partner with Patients through their Kisunla™ treatment journey by offering resources, answering questions, and providing emotional support.

SERVICE SELECTION

Select from the following service offerings. Please use the "DESCRIPTION OF AVAILABLE SERVICES" above as a reference.

Benefits Investigation: Who is conducting the Benefits Investigation? Please select the appropriate option†:

☐ **HCP or Infusion Center Conducted Benefits Investigation**

OR

☐ **Lilly Conducted Benefits Investigation**

Note about Savings Cards: As part of a Lilly Conducted Benefits Investigation, Lilly Support Services™ can research a Patient's insurance to determine eligibility for a Savings Card (Governmental beneficiaries are excluded from Savings Card eligibility; Terms and Conditions apply)

As part of the Lilly Conducted Benefits Investigation, Lilly Support Services™ can also research estimated costs associated with the treatment of Kisunla™. Please select additional costs that you would like investigated:

- ☐ Infusion administration estimate
- ☐ MRI estimate (CPT# 70551: MRI, brain, including brain stem, without dye)

If coverage attempts (e.g., Prior Authorization, Pre-Certification, etc.) are required for Kisunla™, who will complete the coverage attempt?

☐ **Prescribing HCP**

OR

☐ **Referred Infusion Center**

Care Coordination: Would you like to opt in to optional Care Coordination, which includes regular outreach from Lilly Support Services™?

☐ Yes, Prescriber is opting in to Care Coordination

Infusion Center Locator Support: Do you need assistance locating an Infusion Center?†

☐ **Yes, Prescriber is requesting support in locating an Infusion Center**

OR

☐ **No, Prescriber is referring to the following known treatment site (If selected, must fill out Infusion Center Location section below†):**

Infusion Center Location – Must be completed if Prescriber selected a Referral Infusion Site

Infusion Center Type:

☐ **Non-Prescribing MD's Office** ☐ **Hospital Outpatient** ☐ **Stand-Alone Infusion Center** ☐ **Other** _____

☐ **In-Office Infusion Center (same address as in Section 5)**

Office/Hospital/Other Name _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Office Contact _____ **Phone** _____ **Fax** _____

NPI # _____ **PTAN #** _____

Lilly A MEDICINE COMPANY

Lilly Support Services™

PRESCRIPTION AND INFUSION ORDER FORM

Kisunla™ (donanemab-azbt)
injection for IV infusion

PUBLISHED 07/2025

OFFICE: Complete the entire form and submit pages 1-5 to Lilly Support Services™ via fax at 1-844-731-2697 or complete online at https://enroll.lillysupportservices.lilly.com. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Section 7: Patient Information and Diagnosis

Patient Name† (First, MI, Last) _____ **DOB†** (MM/DD/YYYY) _____

Address† _____ **City†** _____ **State†** _____ **Zip†** _____

Allergies _____

Current Medications _____

Other Medical Conditions or Additional Comments: _____

Medical History Related to IV Insertion (e.g., lymph nodes or mastectomy): _____

Diagnosis†

- ☐ **G30.0 Alzheimer's disease with early onset**
- ☐ **G30.1 Alzheimer's disease with late onset**
- ☐ **G30.8 Other Alzheimer's disease**
- ☐ **G30.9 Alzheimer's disease, unspecified**
- ☐ **G31.84 Mild cognitive impairment, so stated**

NOTE: IF PRESCRIBER IS INFUSING IN-OFFICE, SECTIONS 8 AND 9 ARE NOT REQUIRED.

Section 8: Prescription

The Prescriber is requesting the following regarding the prescription and infusion order:

☐ Lilly Support Services™ will triage the prescription and infusion order on the Patient's behalf to the identified Infusion Center. **(IF SELECTED, PLEASE COMPLETE SECTIONS 8 AND 9)**

OR

☐ Lilly Support Services™ will **NOT** triage the prescription and infusion order on the Patient's behalf to the identified Infusion Center. **(IF SELECTED, PLEASE PROCEED to Section 10)**

Kisunla™ Prescription — Fill out corresponding prescription below and sign at the bottom of the page†

You must select at least one Dosing option. You may select multiple Dosing options if they are in sequential order.

Kisunla™ Dosing - Infuse intravenously once every 4 weeks per the dosing schedule below	Quantity	Days Supply	Refills
STARTING DOSES			
☐ Infusion 1: Infuse 350 mg intravenously over approximately 30 minutes	1 vial	28	NA
☐ Infusion 2: Infuse 700 mg intravenously over approximately 30 minutes	2 vials	28	NA
☐ Infusion 3: Infuse 1050 mg intravenously over approximately 30 minutes	3 vials	28	NA
CONTINUED DOSE			
☐ Infusion 4+: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter	4 vials	28	_____

Section 9: Infusion Order Information Protocol

Administration Protocol:

- Observe the Patient post-infusion for a minimum of 30 minutes to evaluate for infusion reactions and hypersensitivity reactions
- At first observation of any signs or symptoms consistent with a hypersensitivity or infusion-type reaction, stop infusion and treat per orders/protocol, as clinically indicated
- Schedule treatments every 4 weeks. Order valid for one year unless otherwise indicated:
  - ☐ Order expires on: _____ ☐ Order expires after _____ treatments

Post-Infusion:

- Send treatment notes to Prescriber via fax to: _____ or via email to: _____

Section 10: Prescriber Signature

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to Eli Lilly and Company, Lilly USA, LLC, their affiliates, agents, representatives, business partners, and service providers (together "Lilly") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to Lilly so that Lilly may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support Lilly provides. I understand that by signing this form, I am requesting support from Eli Lilly and Company for a Patient receiving Kisunla™ pursuant to an FDA approved indication and attest that the Patient is eligible to undergo MRI per the Kisunla label.

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

_____ _____

Prescriber Signature† **Date Signed† (MM/DD/YYYY)**

Not signing this form will result in an incomplete submission and a delay in requested services

Lilly A MEDICINE COMPANY

LILLY CARES® FOUNDATION, INC.

Patient Assistance Program Application

The Lilly Cares Foundation, Inc. (“Lilly Cares”) is a nonprofit organization that offers the Lilly Cares Patient Assistance Program (“Program”) to help qualifying patients obtain certain Eli Lilly and Company medications at no cost. This application form is for patients who would like to apply to receive the available medication(s) at no cost through the Program.

An electronic application is available at www.lillycares.com and is recommended to reduce paperwork and potential delays.

Medications Provided by the Lilly Cares Program

New applications for Trulicity® are temporarily not being accepted, except for limited medical exception cases. Visit lillycares.com/how-to-apply for medical exception requirements and form. Lilly Cares will accept applications for re-enrollment of those currently enrolled for Trulicity.

Group 1 Medications

- Cialis® (tadalafil) tablets
- Emgality® (galcanezumab-gnlm) injection
- Forteo® (teriparatide injection)
- Reyvow® (lasmiditan)
- Trulicity® (dulaglutide) injection

Group 2 Medications

- Basaglar® (insulin glargine injection)
- Humalog® (insulin lispro injection)
- Humulin® (human insulin)
- Lyumjev® (insulin lispro-aabc) injection

Group 3 Medications

- Ebglyss™ (lebrikizumab-lbkz) for injection
- Humatrope® (somatropin) for injection
- Omvoh® (mirikizumab-mrkz) infusion†
- Omvoh® (mirikizumab-mrkz) injection
- Olumiant® (baricitinib) tablets
- Taltz® (ixekizumab) injection

Group 4 Medications

- Alimta® (pemetrexed for injection)†
- Cyramza® (ramucirumab) injection†
- Erbitux® (cetuximab) injection†
- Jaypirca® (pirtobrutinib) tablets
- Kisunla™ (donanemab-azbt) injection†
- Retevmo® (selpercatinib) tablets
- Verzenio® (abemaciclib) tablets

† indicates infused medication

To qualify, you must meet all the requirements listed below:

- Your healthcare provider has prescribed a qualifying Lilly medication.
- You are a permanent resident of the United States, (inclusive of Puerto Rico and the U.S. Virgin Islands).
- You meet the household income guidelines for the program (shown below).
- You are not enrolled in Medicaid, full Low-Income Subsidy (LIS, “Extra Help”), or Veterans (“VA”) Benefits.
- The following applies to you regarding your insurance coverage:
  - Medication Group 1, 2, and 3 Either:
    1) You have no insurance, or 2) you have Medicare Part D (not applicable to infused medications†), or 3) you have Medicare Part B but have no supplemental or secondary insurance (e.g., private insurance offered by former employer, Medigap, Medicare Advantage).
  - Medication Group 4 Either:
    1) You have no insurance, or 2) you have Medicare Part D (not applicable to infused medications†), or 3) you have Medicare Part B but have no supplemental or secondary insurance (e.g., private insurance offered by former employer, Medigap, Medicare Advantage), or 4) if your insurance does not cover the medication, you may still qualify. For details, visit: https://www.lillycares.com/assets/pdf/insuranceverification.pdf.
- For **ALL Medications,** you do not have an insurance plan or third party that requires you to apply to the Lilly Cares Program as a condition, requirement, or prerequisite for coverage of specific Eli Lilly and Company medications. Additional information on such ineligible programs, often referred to as alternative funding programs, for-profit patient advocacy programs, or specialty cost-containment networks (collectively known as "AFPs"), is provided below*.
- If applying for an infused medication, the treatment must be provided in an outpatient setting.
- If your healthcare provider is seeking replacement product for an infused oncology medication that you have already received, you must have received treatment within the last 180 days.

Annual Adjusted Household Income Limit

The dollar amounts listed in this table are based on Federal Poverty Level (FPL) Guidelines. Income limits are subject to change on an annual basis; current limits reflect 2025 FPL guidelines. Please visit www.aspe.hhs.gov/poverty for the most current guidelines.

Total Number of People in your Household (Including you and all family members)	1	2	3	4
Group 1 Medications (at or below 300% FPL)	$46,950	$63,450	$79,950	$96,450
Group 2 Medications (at or below 400% FPL)	$62,600	$84,600	$106,600	$128,600
Group 3 & Group 4 Medications (at or below 500% FPL)	$78,250	$105,750	$133,250	$160,750

If you live in Alaska, Hawaii, or have more than four people in your household please call us at 1-800-545-6962 for adjusted gross income limits.

*The Lilly Cares Foundation offers the Lilly Cares Patient Assistance Program as a charitable program for patients in financial need based on income and other eligibility criteria. If an employer, plan, or other third-party directs patients to apply to the Lilly Cares Program as a condition of, requirement for, or prerequisite to coverage, or in any way adjusts coverage based on application to or availability of the Lilly Cares Program, those individuals are not eligible for the Lilly Cares Program. Moreover, if an employer or plan requires an application to Lilly Cares be submitted by or with an AFP, as defined above, that applicant is not eligible for the Lilly Cares Program, even if eligibility criteria are otherwise met. Applications that violate these requirements will be blocked from participating in the Lilly Cares program, and Lilly Cares reserves the right to take further action as necessary, including against third parties. More information regarding Lilly Cares eligibility criteria as well as a list of AFPs is available at https://lillycares.com/assets/pdf/toapplycheckEligibility.pdf.

How do I apply to the Lilly Cares Program?

To apply, you must complete the following steps:

1. Access the latest Program application at www.lillycares.com or by contacting Lilly Cares. Outdated applications will not be accepted.
2. Confirm you **qualify** for **the Lilly Cares Program** (page 1)
3. Read the **Privacy Notice** (page 3)
4. Complete the **Patient Information Section** (pages 4 and 5)
5. Read and sign the **Patient Certification Agreement** (page 6)
6. Read and sign the **Health Insurance Portability and Accountability Act (HIPAA) Authorization** (page 7)
7. Ask your healthcare provider to **complete and sign the Healthcare Provider/Prescriber Section** (pages 8 and 9)
8. **Fax the completed and signed application to Lilly Cares** (or have your healthcare provider's office do this for you). If you have insurance and you're applying for a Group 4 or an infused Medication, include insurance verification documentation.* For details, visit: https://www.lillycares.com/assets/pdf/insuranceverification.pdf.

   Fax number: 1-844-431-6650

   *Insurance documentation is not required for Medicare Part D patients applying for a Group 4 self-administered product
9. After review of your application, a **letter will be sent to you and your healthcare provider** notifying you of whether you qualify for the Lilly Cares Program.

Use of Third Parties to Apply

Lilly Cares does not charge patients a fee for help with enrollment, medication refills, or for participation in the program. Lilly Cares is not affiliated with third parties that charge for assistance that Lilly Cares provides to you at no cost. For support, please call Lilly Cares at 1-800-545-6962.

Privacy Notice

This Privacy Notice ("Notice") is to provide you with information about the personal information, including health information and financial information, that the Lilly Cares Foundation, Inc. ("Lilly Cares") (collectively, "we", "us" or "our") may collect, use, disclose, or otherwise process, and your rights and choices with respect to your information. This Notice is intended to supplement the **Eli Lilly and Company Privacy Statement (https://privacynotice.lilly.com)** and the **Consumer Health Privacy Notice (https://www.lillyhub.com/legal/lillyusa/CHPN.html)** that can be accessed in the footers of Eli Lilly and Company's websites. Lilly Cares may transmit personal information about you to Eli Lilly and Company and its affiliates worldwide including their employees, agents, contractors, vendors, subsidiaries, and business partners (who may be assisting with the administration of Lilly Cares and the Lilly Cares Patient Assistance Program ("Program")).

The categories of health information we collect will depend on how you interact with our services and the information you choose to provide. We may collect:

- Health conditions, treatments, diseases, or diagnosis
- Social, psychological, behavioral, and medical interventions
- Health-related surgeries or procedures
- Use or purchase of prescribed medication
- Bodily functions, vital signs, symptoms, or measurements of other types of consumer health data
- Diagnoses or diagnostic testing, treatment, or medication
- Reproductive or sexual health information
- Biometric data
- Genetic data
- Data that identifies a consumer seeking health care services
- Prescription and medical health insurance benefits information
- Other information that may be used to infer or derive data related to the above or other health information.

With your consent, we may use the health information we collect for the following purposes, as further described in our privacy statements:

- Providing services and support.
- Analytics and improvement.
- Customization and personalization.
- Marketing and advertising.
- Security and protection of rights.
- Legal proceedings and obligations.
- General business and operational support.

We do not sell or share your health information with third parties without your consent or authorization. We may disclose health information to entities or persons that work as processors on our behalf to provide you with services you request, including administration of the Program.

We may use and save your personal information and health information to meet legal or regulatory obligations that are in our legitimate interest, to fulfill legitimate and lawful business purposes (consistent with the charitable purposes of Lilly Cares), in accordance with our record retention policies and applicable laws and regulations, and to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests.

Some of this personal information may be considered sensitive under applicable laws, such as information about your health or medical diagnosis and demographic information collected in some circumstances, such as race, ethnic origin, and sexual orientation. We may process your sensitive Personal Information with your consent, or as otherwise permitted by law.

Upon verification, you have rights with respect to the collection, use, and storage of your information. These rights may include access to your information and how it is being used or shared, the right to correct, delete, or limit use of your information or to withdraw consent for us to collect and use your information. There may be certain exceptions and limitations that apply to your request including the right to have your information transmitted to another entity or person in a machine-readable format. To exercise your rights, you or your authorized representative may submit a request to **datarights@lilly.com** or 1-800-Lilly-Rx (1-800-545-5979) (which will respond to the request on behalf of Lilly Cares and the above-referenced entities). You will not be discriminated against for exercising any of your rights. You may be entitled, in accordance with applicable law, to appeal a refusal to take action on your request. To do so, please contact us by using one of the methods listed here or in How to Contact Us section of the online Privacy Statement.

If you wish to raise a complaint on how we have handled your personal information, you can contact the Eli Lilly and Company Global Privacy Office and Data Protection Officer at **privacy@lilly.com**, who will investigate the matter (on behalf of Lilly Cares and the above-referenced entities). If you are not satisfied with our response or have any concerns about how your data is being processed, you can register a complaint with a relevant regulatory authority (e.g., a Data Protection Authority (DPA) or Attorney General).

Patient Information Section

Please fill out all fields on this page. If your application isn't complete, it might delay your enrollment in the Lilly Cares Program.

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First Name **Middle Initial** **Last Name**

Address

City **State** **ZIP Code**

Date of Birth (MM/DD/YYYY) **Phone Number** (optional)[1]

Where would you like your medication delivered?[3]

- ○ To my home
- ○ To my healthcare provider's office

[1] By providing your phone number and signing this form, you agree to receive automated phone and text messages[2]. These notifications may include updates on enrollment status or medication shipments. Your phone number is not mandatory for applying to the Program. Message and data rates may apply. You can opt out by calling 1-800-545-6962. Infused medications are not eligible for automated messages.

[2] 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).

[3] Consult with your healthcare provider to confirm delivery location. Infused medications are not eligible for home delivery.

Patient Income Information

Number of people in your household
Including you and all family members.

Annual Household Income before taxes[4, 5]
Include wages, Social Security payments, disability and/or unemployment benefits, pensions, and any other income of yourself and those in your household.[5]

[4] Enter 0 for no household income.

[5] When processing your application, you may be contacted by Lilly Cares to provide documentation showing your income.

Patient Insurance Information

Has your employer, insurance company, or their appointed representative directed you to seek enrollment in this program as a requirement of your drug coverage plan? This does not include your healthcare provider or their office, specialty pharmacy, or a family member.

○ No ○ Yes

What type of health insurance do you have? (Check all that apply) [6]

[6] *When processing your application, a benefits verification will be conducted. Insurance documentation may be requested.*

- ☐ I do not have health insurance

Medicare

- ☐ Medicare Part D [7]
- ☐ Medicare Part B **without** supplemental/secondary insurance [8]
- ☐ Medicare Part B **with** supplemental/secondary insurance [8]
- ☐ Medicare Advantage Plan

Other Insurance Type

- ☐ Medicaid
- ☐ VA or Military
- ☐ Private Insurance (excluding Medicare Part D) [9]

For Group 4 Medications, has your insurance denied coverage for the prescribed product?

○ No ○ Yes - *If yes, please include documentation. For details, visit: https://www.lillycares.com/assets/pdf/insuranceverification.pdf*

[7] An insurance card for Medicare Part D Prescription Drug Plans (PDP) usually includes a reference to "Medicare Rx" or "PDP" on the front or back of the card.

[8] For example, Medigap, Medicare Advantage, employer private insurance.

[9] For example, employer-sponsored plan and health insurance marketplace plan.

Patient Information Section

We encourage you to choose an answer for the next 2 questions right now, but if you don't, it won't delay your application to the Lilly Cares Program.

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Patient Authorization for Automatic Prescription Refills ("Auto-refill")

If your prescription allows refills, Lilly Cares can automatically fill your medication when you are due for a refill. If you've provided your cell number, we will send you a text message letting you know when your medication has shipped. When you have zero refills remaining, we will contact your healthcare provider for a prescription renewal before your next refill due date. Auto-refills will stop at the end of your program enrollment period or when your prescription has no more renewals.
If you no longer need the medication or to opt out of auto-refills, contact Lilly Cares at 1-800-545-6962. Infused medications are not eligible for auto-refills.

- ◯ Yes, automatically fill my medication when I am due for a refill.
- ◯ No, do not automatically refill my medication. I will call Lilly Cares when I am due for a refill.

Patient Authorization to Speak with Authorized Representative

You may provide the names of one or more people with whom you authorize Lilly Cares to speak on your behalf about this application or your participation in the Lilly Cares Program. These people can provide or receive your personal information as necessary until the end of your enrollment period unless you request their authority be terminated prior to then.

- ◯ Yes, I'd like to authorize a person to speak on my behalf.
- ◯ No, I do not want anyone speaking to Lilly Cares on my behalf.

If you've opted "yes", please provide the name of at least 1 authorized representative below. By providing the name(s) below, you certify that individuals are aware and agree that you will provide their name to Lilly Cares for the purpose of serving as your authorized representative.

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

Name of Authorized Representative 1 (Please print)

Relationship to Patient (Please print)

- ◯ Family Member/Caregiver
- ◯ Other, please specify

Name of Authorized Representative 2 (Please print)

Relationship to Patient (Please print)

- ◯ Family Member/Caregiver
- ◯ Other, please specify

Patient Certification Agreement

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I understand that:

- I understand that I or my healthcare provider's office is submitting this application to see if I qualify for assistance with my Eli Lilly and Company medications through the Lilly Cares Foundation, Inc. ("Lilly Cares"). I understand that before Lilly Cares can assist me, Lilly Cares may need to collect, use, and share information about me. When I sign below, I am authorizing any pharmacy, healthcare provider, and/or others who are in possession of my personal information, including protected health information (PHI), to share such information about me with Lilly Cares, Eli Lilly and Company, and its affiliates worldwide including their authorized employees, agents, contractors, vendors, subsidiaries, and business partners who may be assisting with the administration of Lilly Cares, including health information. In addition, I understand and am authorizing the sharing, use and disclosure of my information, inclusive of health information, for the purposes of operating Lilly Cares as explained in the Privacy Notice section above.
- Lilly Cares will decide if I qualify for the Lilly Cares Patient Assistance Program ("Program"). I understand that my application might not be approved. Lilly Cares may change or end the Program, or terminate my enrollment in the Program, at any time.
- **Lilly Cares does not charge a fee to apply for participation in the Program**. 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 medication, this money is not paid to Lilly Cares.
- If my application is approved, my approval letter will tell me when my enrollment will expire (generally in 12 months or at the end of the calendar year for those with Medicare Part D). After my enrollment expires, I will need to reapply to the Program.
- For infused medications, I must have received treatment within 180 days of application approval, if granted.
- If I do not sign or refuse to sign this form, I will not be eligible for the Program.

I certify (agree) that:

- I am a permanent resident of the United States, Puerto Rico, or U.S. Virgin Islands.
- My application is complete and accurate. I have been truthful about my insurance coverage and income.
- I meet the Program eligibility criteria, including income and insurance coverage requirements, as shown on page 1 of this application.
- I will promptly provide documentation supporting the information I have provided in this application (e.g., income verification documents, pharmacy and medical health insurance benefit documents) if such documentation is requested by Lilly Cares. Failure to promptly provide complete and accurate documentation when requested may result in immediate termination of application review or removal from the Program if application has already been approved.
- 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, and address 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 for the Program. This 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 understand Lilly Cares may request proof of my annual income and a consumer report as a requirement for enrollment in the Lilly Cares Program.
- I authorize the Lilly Cares Program representatives to use my name, date of birth, and address to conduct a manual or electronic benefits investigation of any applicable pharmacy and medical health insurance benefits in connection with this application. I understand Lilly Cares may request proof of these benefits as a requirement for enrollment in the Lilly Cares Program.
- If my application is approved:
  - I will notify Lilly Cares of changes to my income or insurance status.
  - I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Lilly Cares Program.
  - If I have Medicare Part D coverage, I will not seek to have the cost/value associated with the medication I receive through the Program counted as out-of-pocket costs for prescription drugs.
  - If I have Medicare Part D coverage, I will inform my Part D Plan about my enrollment in Lilly Cares.
  - I will not sell, trade, or transfer any medication I receive through the Program.
  - If directed by provider, I consent to medication being shipped to provider.

Name of Patient (Please Print)

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (REQUIRED)

Date (MM/DD/YYYY)

Please fill out all fields and sign this form. If you don't, it might delay your enrollment in the Lilly Cares Program.

Health Insurance Portability and Accountability Act (HIPAA) Authorization

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

I understand that I or my healthcare provider's office is submitting this application to see if I qualify for assistance with my Eli Lilly and Company medications through the Lilly Cares Foundation, Inc. ("Lilly Cares"). I understand that before Lilly Cares can assist me, Lilly Cares may need to collect, use, and share information about me. When I sign below, I am authorizing any pharmacy, healthcare provider, and/or others who are in possession of my personal information, including health information, and protected health information (PHI), to share such information about me with Lilly Cares, Eli Lilly and Company and its affiliates worldwide including their authorized employees, agents, contractors, vendors, subsidiaries and business partners who may be assisting with the administration of Lilly Cares ("Receiving Entities"). In addition, I understand and am authorizing the Receiving Entities to share, use, and disclosure of my information for the purposes of operating the program.

The Receiving Entities may receive, share, and use the following information:

- Information in this application.
- Information about your medical conditions, treatment, current and future medications.
- Information about your health insurance or benefits (prescription and medical), including how much coverage you have.
- Other information the Receiving Entities may obtain to operate Lilly Cares.
- The Receiving Entities may share your information with your healthcare providers and pharmacists.
- Your healthcare providers and pharmacists may share your information with the Receiving Entities.

The Receiving Entities may share your information for the following purposes:

- To review your application to determine your eligibility and to contact you or your healthcare provider, if necessary, for that review.
- To help operate Lilly Cares and for the Receiving Entities' internal purposes involving other patient assistance and charitable programs.
- To your pharmacies and healthcare providers relating to your participation in the Lilly Cares Program, including personal information and information about your prescription medications.
- To learn how much of your Eli Lilly and Company medication is covered by your insurance.
- Track use of medication.
- To measure program performance and make program improvements.
- We only ask for and share the PHI that we need to operate the Program. We do not ask for any PHI that we don't need, but we may receive some in health records sent to us.

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

- You don't have to give permission to share your PHI with Lilly Cares, but we may not be able to assist you without it.
- After your PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again.
- I understand that Program representatives can contact me to collect any additional information needed to provide these services to me.
- This authorization allows those who rely on it to release my PHI for 3 years from the date I have signed it unless I am a resident of Maryland, Maine or Montana, in which case the permission will last for 1 year from the date of signature.
- I understand that I can cancel my consent at 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 the Lilly Cares Program. My healthcare providers will no longer share my PHI with the Receiving Entities after the date that the Receiving Entities receive and process my cancellation letter, but this will not affect information or disclosures shared before that time. Additionally, once my cancellation is received and processed by the Receiving Entities, my participation in the Lilly Cares Program will be terminated, and after my participation is terminated, the Receiving Entities will only maintain and use my information for legal and regulatory purposes.
- I have the right to receive a signed copy of this HIPAA authorization or ask my healthcare provider for a copy.

Name of Patient (Please Print)

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (REQUIRED)

Date (MM/DD/YYYY)

Please fill out all fields and sign this form. If you don't, it might delay your enrollment in the Lilly Cares Program.

End of Patient Section

Healthcare Provider (doctor or nurse) to fill this section out.

Healthcare Provider/Prescriber Section

Confirmations and Agreements

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By signing below, I (the "Prescriber") certify to the following statements:

- The information provided is accurate to the best of my knowledge.
- I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient provided in the Healthcare Provider/Prescriber Section ("Patient"), to the Lilly Cares Foundation, Inc. ("Lilly Cares"), Eli Lilly and Company, and its affiliates worldwide including their employees, agents, vendors, business partners, and Program representatives who may be assisting with the administration of Lilly Cares for the purpose of assessing whether the Patient qualifies for the Lilly Cares Patient Assistance Program ("Program") through the duration of the Patient's therapy. Prior to signing this form, I have ensured the Patient is aware of, has consented to, and has directed my disclosure of their information to Lilly Cares so that Lilly Cares may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient therapy.
- 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 also will comply with applicable laws related to disposal of, and will properly dispose, unused medication.
- I prescribed the above-referenced medication (the "Medication") to the Patient listed on this form based on my independent clinical judgment that treatment with this Medication for the Patient is medically necessary.
- Any ICD-10 code I have provided is accurate, and for an FDA-approved indication and/or compendia use for the Medication I have prescribed for this Patient.
- To the best of my knowledge the Patient meets the financial need, insurance, and residency requirements of the Lilly Cares Program. If I become aware the Patient may no longer meet the criteria for the program, I agree to 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.
- I acknowledge and agree that any Medication provided by Lilly Cares for this Patient cannot be resold, nor offered for sale, trade, or barter, nor returned for credit (each a "Financial Use") I certify that I will not make or permit any Financial Use of any Medication provided by Lilly Cares.
- If the Patient has insurance, a claim or request has been made to that insurer, that claim has been denied, an appeal to the insurer has been completed and I have received a denial for that appeal as required by the program guidelines.
- If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, I agree not to seek reimbursement for that product, and to notify Lilly Cares of the availability of reimbursement. If I receive any subsequent reimbursement from any source for product supplied without cost by Lilly Cares, I will notify Lilly Cares and will follow Lilly Cares instructions regarding those funds. I acknowledge that I am not permitted to receive financial benefit from product provided by Lilly Cares.
- If I elect to receive Medication from Lilly Cares under the Proactive Provision program, I will complete any requested documentation, will notify Lilly Cares if any product is not administered to the applicable enrolled Patient and will return the product to Lilly Cares or appropriately destroy the product at the facility (if requested by Lilly Cares) and submit documentation to Lilly Cares confirming that the product has been appropriately destroyed.

I understand:

- Lilly Cares will only provide Medication to the extent consistent with its tax-exempt purposes, qualified under Section 170(e)(3) of the Internal Revenue Code, and authorized by Lilly Cares policies, which may include the providing of Medication to me (as the eligible Patient's healthcare provider) for the sole purpose of caring for the ill, needy, indigent and/or infants in the United States.
- Lilly Cares may change, terminate, suspend participation, limit enrollment, or recall/discontinue Medications in the Program without prior notice.
- Lilly Cares does not charge a fee to apply for participation in the Program. Patient is not required to use a third party that charges a fee to help Patient with enrollment, and if Patient uses a third party that charges a fee to help with their enrollment or refills of Medication, this money is not paid to Lilly Cares.
- I am under no obligation to purchase or prescribe any Eli Lilly and Company drug to participate in this program and I certify that I have not received, and I understand that I will not receive any benefit from any Program representatives for prescribing an Eli Lilly and Company drug.
- Program representatives are not responsible for filing any insurance claim.
- The information provided will be subject to potential reviews by Lilly Cares.
- Fax communications sent to a single number may split to multiple Receiving Entities for the purpose of operating the Program.
- I am to provide the Patient a signed copy of their HIPAA authorization upon request.
- If I elect to receive Medication from Lilly Cares under the Proactive Provision program and I do not return or destroy the product provided and not used for the applicable enrolled Patient, I will be billed for the product (or demand for equivalent payment in method determined appropriate by Lilly Cares to ensure that healthcare provider does not benefit from product provided by Lilly Cares) and I will be responsible for payment of the bill. Please contact Lilly Cares at 1-800-545-6962 for assistance with product returns.

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

Patient Name (Please print)

Date of Birth (MM/DD/YYYY)

Medication(s) Requested Specify Formulation Type

Office Contact Name

Office Contact Phone

Office Contact Fax

Date (MM/DD/YYYY)

Prescriber Name (Please print)

PRESCRIBER SIGNATURE (REQUIRED)

Please indicate the method for submitting a prescription to Lilly Cares. Please read carefully and submit prescription via one method only.

- ◯ Electronic prescription: select Neovance Specialty Pharmacy (NPI 1780811125) in the eRx software.
- ◯ Fax prescription to 1-844-431-6650 using the optional prescription template on page 9 of the application, resources on lillycares.com, or provider generated prescription.

DO NOT complete page 9 of the application if submitting an electronic prescription or faxing a provider-generated prescription.

Infused ONCOLOGY ICD 10 Code
Required for Alimta®, Cyramza®, & Erbitux® ONLY:

(Infused oncology medications must be used only for an FDA approved indication or compendia-supported use.)

Infused ONCOLOGY Product Replacement Request

A prescription is not required for product replacement

◯ Alimta ◯ Cyramza ◯ Erbitux

Administration Date	Dosage	# of Vials	Vial Size

Please fill out all fields and sign this form. An incomplete form may delay the patient's enrollment in the Lilly Cares Program.

Healthcare Provider: DO NOT complete if submitting an electronic prescription or faxing a provider generated prescription

Lilly Cares Prescription Template

Patient Information

Note: If the patient's application is approved, medication will be delivered to the location selected by the patient. Please coordinate with your patient to ensure appropriate delivery location. Infused medications are not eligible for home delivery.

New applications for Trulicity are temporarily not being accepted, except for limited medical exception cases. Visit lillycares.com/how-to-apply for medical exception requirements and form. Lilly Cares will accept applications for re-enrollment of those currently enrolled for Trulicity.

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Please fill out all fields. An incomplete form may delay the patient's enrollment in the Lilly Cares Program.

Patient Name

Date of Birth (MM/DD/YYYY)

Address

City

State

ZIP Code

Phone Number

Drug Allergies

Other Medications

Rx: I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy. To submit an electronic prescription, please select Neovance Specialty Pharmacy (NPI 1780811125) in your eRx software.

Medication

Strength

Maximum Dose per Day

Directions (Please print)

Are you prescribing insulin?

◯ Yes ◯ No

If yes, select the prescribed insulin:

◯ Vial (not available for Basaglar®, Humalog® U-200, Humalog® 50/50, Humulin® U-500, or Lyumjev™ U-200)
◯ KwikPen® (not available for Humulin® R-100 units/mL)
◯ Cartridge (only available for Humalog® 100 units/mL)

Refill #

Quantity to be Dispensed (oncology medications are limited to a ONE-month supply)

◯ 4 Month (max) ◯ 3 Month ◯ 2 Month ◯ 1 Month

Your state may require that prescriptions follow certain content requirements or use a particular form. Non-compliance with state-specific requirements will result in outreach to the prescriber and may delay shipping of medication. 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. I authorize Lilly Cares to act on my behalf for the limited purposes of transmitting this order for prescription medication.

Select one: ◯ Dispense as written ◯ Substitution Brand Exchange Permitted

PRESCRIBER SIGNATURE

Today's Date (MM/DD/YYYY)

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

Healthcare Provider Information

Healthcare Provider Name and Title (Please print)

DEA # (as required)

State License # and State

NPI #

Address

City

State

ZIP Code

Phone Number

Fax Number

Office Contact Name

Office Contact Phone