Lilly Cares Foundation, Inc.

Lilly Cares Patient Assistance Program
P.O. Box 230999 - Centreville, Virginia 20120 - **1-800-545-6962** This blank form may be photocopied.

Lilly Cares Foundation, Inc. ("Lilly Cares"), which is a nonprofit, tax exempt charity affiliated with Eli Lilly and Company ("Lilly"), provides a patient assistance program that supplies certain medications, free of charge, to qualifying U.S. residents who need temporary assistance in obtaining their Lilly or Dista medications. To apply for the program, the patient and physician must complete this application. If the patient qualifies for the Lilly Cares Program, **product is sent to the physician** for distribution. Product will **generally** arrive at the physician's office within **4 weeks** after we receive a complete application. Insulin coupons will be sent directly to patients.

NOTE: Patients eligible for Medicare are not eligible for this program. They may wish to apply for a Medicare Prescription Drug Plan by calling 800-MEDICARE or at www.medicare.gov

PLEASE COMPLETE ALL BLANKS ! THE MOST COMMON CAUSE OF DELAY IS…MISSING INFORMATION !

Step ONE: Physician Information (Physician please print clearly)

Physician Name: ____

Shipping Address: (Do **NOT** use PO Box) ____

____

City: ______________________ State: __________ Zip: ____________

Phone: ___ ___ ___ -- ___ ___ ___ -- ___ ___ ___ ___

Prescription Information

Patient Name: ____

Product Requested: ____

Dosage: ______________ Sig: ______________ Quantity: ____________

A four-month supply will be supplied unless a lesser amount is requested.

State License # or DEA # ______________________ Expiration Date __________

Healthcare provider certification: My signature immediately below attests to my understanding and agreement that medications received from Lilly Cares for patient assistance are only for the use of the patient named on this form. I further agree that these medications will not be offered for sale, trade, or barter, and are for the care of the ill, the needy, or infants at no charge to the patient. I also understand that Lilly Cares has the right to contact the patient directly to confirm receipt of medications, and to revise, or to terminate the program at any time.

Physician Signature: ______________________________ Date: ______ / ______ / ______

Original Signature Only; No Photocopies or Stamps

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Step TWO: Patient Information (Patient please print clearly)

Patient Name: ____
Last First MI

Address: ____

City: ______________________________ State: __________ Zip: ______________

Phone ________ - ________ - ________ SSN: ________ - ________ - ________

Patient is: Male _____ Female _____ Date of Birth: ________ / ________ / ________

Is this patient covered by ANY prescription drug plan? Yes________ No________

If yes, what is the name of the plan? ______________________________

Total Number of People in household: ________ (Include ALL people living in your household)

Total Current Monthly Household Income: $ ______________ (a COPY of the first page of your most recent Income Tax Return, or other proof of income, MUST be included with this application.)

Step THREE: **Patient Authorization and Certification** (Patient must sign below)

By my signature below, I confirm that,

• I request assistance from this Patient Assistance Program.

• I agree to abide by the rules, procedures, and conditions of this program.

• The information I have set forth in this application is true, correct, and complete;

• I understand and authorize Lilly Cares, Lilly, and any entity it may contract with to be the administrator for this program (referred to as the "Administrator"), to receive the information contained in this application, information on the prescription medicines that my doctor has provided or will provide me, and other information that they may obtain about me in operating and administering this program (the "Information"). I further authorize Lilly Cares, Lilly, and/or the Administrator to use the Information: to review my application and contact me, or my healthcare provider, as necessary to conduct such review; for purposes relating to the operation and administration of this program; and for internal business purposes (such as developing other programs and services). I understand that this Information will not be shared with other parties, but that certain non-personal portions of the Information (for example, general location, age, gender) may be shared with other parties for purposes of operating or analyzing this program. I understand that I have the right to revoke this Authorization at any time by writing Lilly Cares at the address set forth on this application. If I revoke this Authorization, I will no longer be eligible for the program.

• I understand that I cannot use this program and also use a Medicare Prescription Drug plan.

• I am NOT enrolled in a Medicare Prescription Drug Plan, AND if I do enroll in a Medicare Prescription Drug Plan in the future, I will immediately notify Lilly at the phone number and/or address on this application;

• I am NOT eligible for, and do not have, any government or private insurance that covers or helps me pay for my medications.

• I understand that eligibility under this program is subject to approval by Lilly Cares and/or the Administrator, and that applying does not guarantee inclusion in the program. I understand that the program may be changed or terminated at any time without prior notice.

Patient Signature: ______________________________ Date: _____ / _____ / _____

Step FOUR: Mail Application, and a COPY of your proof of income!

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