Lilly Cares Foundation, Inc.

Lilly Cares Patient Assistance Program
P.O. Box 230999 | Centreville, Virginia 20120 | 1-800-545-6962

Blank form may be photocopied.

Lilly Cares is a patient assistance program provided by Eli Lilly and Company, which is free of charge for 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 **4 weeks** after we receive a complete application. Insulin coupons will be sent directly to patients.

CAUTION: PLEASE FILL OUT ALL PORTIONS, AN INCOMPLETE APPLICATION WILL RESULT IN A DELAY IN PROCESSING THIS REQUEST.

Step One Physician Information (Physician please print clearly)

Physician Name: _____

Shipping Address: (DO NOT USE P.O. 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 # _____

Healthcare provider certification: My signature attests that medications received from Lilly for patient assistance are only for the use of the patient named on this form. These medications will not be offered for sale, trade, or barter. I also understand that Lilly has the right to contact the patient directly to confirm receipt of medications, and to revise, or 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: _____ SSN: _____ _____ _____
Last First M

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ . _____ . _____ Phone: (_____) _____

Number of People in household: _____ (Includes ALL people living in your household)

Total Monthly Household Income: $ _____

Male: ☐ Female: ☐

Insurance Information

1. Is this patient covered by Medicare? Yes ☐ No ☐

STOP: IF YOU ANSWERED YES, YOU NEED A LILLYANSWERS® APPLICATION.
PLEASE CALL 1-877-795-4559 or visit www.LillyAnswers.com

2. Does this patient have any prescription coverage? Yes ☐ No ☐

If yes, please name coverage: _____

Patient Authorization and Certification

I understand that Eli Lilly and Company ("Lilly") and any entity it may contract with to be the program administrator for Lilly Cares (referred to as the "Administrator"), will 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 the Lilly Cares program (the "Information"). I hereby authorize the Administrator and/or Lilly 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 Lilly Cares; and for Lilly's 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 Lilly Cares. I understand that I have the right to revoke this Authorization at any time by writing Lilly at the address set forth on this application. If I revoke this Authorization, I will no longer be eligible for the program.

I certify that the information I have set forth in this application is true, correct, and complete. I understand that eligibility under this program is subject to approval by Lilly and/or the Administrator, and that application to the Lilly Cares program does not guarantee inclusion in the Lilly Cares program. I understand that the Lilly Cares program may be changed or terminated at any time without prior notice.

Patient Signature: _____ Date: _____ / _____ / _____