# *Lilly Cares Foundation, Inc.*

**(Temporary Prescription Assistance Program)**
**P.O. Box 230999 Centreville, Virginia 20120 1-800-545-6962**

SAMPLE

**PART ONE – PRESCRIPTION INFORMATION:** (This blank form may be photocopied for future use.)

**Patient Name**: JOHN DOE **Date**: 1-23-45

**Product Requested** (NOT VALID FOR CONTROLLED SUBSTANCES): ZYPREXA or ZYDIS
[If insulin, please specify Iletin®, Humulin® or Humalog® type. If sliding scale, indicate maximum unit daily dosage.]
Aventyl® HCl (Nortriptyline Hydrochloride), Evista® (Raloxifene Hydrochloride), Prozac® (Fluoxetine Hydrochloride), Strattera™ (Atomoxetine Hydrochloride), Zyprexa® (Olanzapine), Zyprexa® Zydis® (Olanzapine Orally Disintegrating Tablets).

**Dosage**: 5 mg **Sig**: 1 bid **Quantity**: 4 months
A four-month supply will be supplied unless a lesser amount is requested

**Physician Signature**: SSSSSSSSSSSS **Date**: 1-23-45
Original Signature Only; No Photocopies or Stamps

**PART TWO – PRESCRIBER INFORMATION: (please print clearly)**

**Physician Name**: X. DOE, M.D. **DEA #:** 9876543210

**Facility Name**: LONG BEACH MHC **Phone**: 123-456-7890

| | |
|---|---|
| **Mailing Address**: 1975 LONG BEACH BLVD. | **Shipping Address**: 550 SO. VERMONT, ROOM 903 (DO NOT USE P.O. BOX) |
| **City**: LONG BEACH | **City**: LOS ANGELES |
| **State**: CA **Zip**: 90806 | **State**: CA **Zip**: 90020 |

**State License No/Expiration Date :** ABC123

**PART THREE - PATIENT INFORMATION: (please print clearly)**

**Patient Name**: JOHN DOE (Last / First / MI) **SSN**: 123 / 45 / 6789

**Address**: 123 SOUTH STREET **City**: LONG BEACH

**State**: CA **Zip**: 90000000 **Date of Birth**: 01-02-3456 **Phone**: 123-456-7890

**Number of people in household**: (1,2,3...) **Total monthly household income: $** $200.00
(all sources for all household occupants – earnings, SSI, SSDI, pension, unemployment, alimony, child support, food stamps, etc.)

**Male** ☑ **Female** ☐

**If income listed as 0, please explain means of support**: e.g., "HOMELESS"

**Liquid assets: $** 0 **Monthly Medical Expenses: $** 0
(stocks, bonds, IRAs, checking/savings)

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Continued: SAMPLE

**PART FOUR – INSURANCE INFORMATION**

**1. Is this patient covered by Medicare:** **Yes**_____ **No** ✔

**2. Does this patient have any prescription coverage**: **Yes**_____ **No** ✔

**If yes, please explain**:_____

**3. Has the patient applied for any of the following:**

**Medicaid - Yes** ✔ **No**_____ **Status** PENDING

**Supplemental Security Insurance (SSI) Yes** ✔ **No**_____ **Status** PENDING

**Social Security Disability (SSDI)** **Yes**_____ **No** ✔ **Status**_____

**ATTENTION ZYPREXA APPLICANTS**:

**If coverage has been denied by any of the above programs, Please attach the letter of denial with this form.**

(If denied, may use DMH "Denial" form letter.)

**Patient Authorization and Certification**

I authorize Eli Lilly and Company and their consultants to use this information to assess my eligibility for participation in the Lilly Cares program. I understand that while this assistance is free of charge, it is temporary, and I may be asked to reapply at designated intervals. I certify I do not have the ability to pay for my medication and that I have no government or private insurance to help pay for my medication.

**Patient (or guardian) Signature**: SSSSSSSSSSSSS **Date**: 1-23-45

**DIRECTIONS FOR COMPLETING APPLICATION**

**PROVIDERS:**

Please complete Parts 1 and 2 of the application. Please print clearly.
Original signatures only, no stamps or photocopies.
Product will only be delivered to a street address, not a P.O. Box.

**PATIENTS**:

Please complete Parts 3 and 4 of the application. Please print clearly.
Number of people in household includes EVERYONE living in the home.
Enter the DOLLAR amount for the following categories: Monthly Household Income, Household Liquid Assets.
Household income includes the following: Social Security, disability, Supplemental Security Income (SSI), unemployment, workman's compensation benefits, child support, alimony, loans, Pensions, interest, etc.

**AN INCOMPLETE FORM WILL RESULT IN A DELAY IN PROCESSING THIS REQUEST**