



Lilly Cares Foundation, Inc

PO Box 230999
Centreville VA 20120
1-800-545-6962

To: Health Care Professionals
From: Lilly Cares Foundation, Inc

Re: NEW APPLICATION for LILLY CARES beginning January 1, 2007

We are pleased to announce two significant and positive changes to the Lilly Cares patient assistance program.

- Lilly Cares patient assistance program has been changed from a 4-month program to a **12-month program**. Once a patient is accepted into the program, the patient will not have to re-apply until the following year. This change eliminates the need for you to complete several applications for each patient in the same calendar year.
- Medication will continue to be shipped to your office (except insulin products) in a 4-month supply (or lesser amount if you indicate). To refill your patient's medication, you need only complete and return the enclosed **Fax Refill Request Form** while your patient is covered under the program.

To ensure your patients are served quickly and effectively, we have enclosed the new 2007 Lilly Cares application form, which reflects these and other program changes. Please discard all prior application forms. Prior versions of the application will not be accepted and may delay the processing of your patient's application.

If you need additional copies of the new application, you may photocopy the enclosed application, download a copy from the Lilly Cares website at www.lillycares.com, or request additional applications by contacting Lilly Cares at 1-800-545-6962.

We appreciate your participation and hope that you will continue to find the Lilly Cares program to be of benefit to your patients.

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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 US residents who need temporary assistance in obtaining their Lilly medications.

- To apply for the program, the patient and physician must complete this application.
- If the patient is approved for the Lilly Cares program, **medications are delivered to the prescriber** for distribution to the patient. Medications generally will arrive at the prescriber's office **4 weeks** after Lilly Cares receives a completed application. Insulin coupons will be delivered directly to patients.
- Patients are accepted into the program for a 12-month period, after which they must re-apply annually.
- The prescriber's office will request refills by faxing the Fax Refill Request Form (form enclosed with each medication shipment) to Lilly Cares.

Step One: Prescribers Information (please print clearly)

Prescriber's Name: _____
 M.D. D.O. N.P. P.A.

Mailing Address: Street: _____ City: _____ State: _____ Zip: _____

Shipping Address: _____
(IF NOT MAILING ADDRESS) (DO NOT USE PO BOX)

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Medication Information

Patient Name: _____

Product Requested: _____ Dosage: _____

Signature: _____

Quantity: _____

A 4-month supply of the product will be provided unless a lesser amount is requested.

Healthcare Provider's Attestations and Agreement To Participate In Program:

Lilly Cares agrees, to the extent consistent with its exempt purposes, qualified under Section 170(e)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and authorized by Lilly Cares policies, to provide medicines, prescription drugs, and other pharmaceutical products, medical supplies, and property (the "Medications") to the prescriber (the "Healthcare provider") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients"). The Healthcare provider agrees to deliver the Medications received from Lilly Cares only to Qualifying Patients at no charge of any kind and further agrees not to use any of the Medications for any other purpose.

My signature immediately below attests to my understanding and agreement to the above Program requirements. I further attest that I am licensed in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above patient. I further attest that if Medications are received from Lilly Cares as a result of this application, such Medications will only be provided to the patient named on this form at no charge. I further attest that this Medication will not be offered for sale, trade, or barter. I understand that Lilly Cares has the right to contact the patient directly to confirm receipt of the Medications, and to revise or terminate the Program at any time. I further attest that all Medications previously received from Lilly Cares and distributed by me were distributed only to Qualifying Patients.

Prescriber Signature: _____

Original Signature Only; No Photocopies or Stamps

Date: _____ / _____ / _____

State of license: _____

State License # _____

License expiration date: _____

Step Two: Patient Information (Patient please print clearly)

Patient Name:(Last) _____ (First) _____ (MI) _____

SSN: _____ - _____ - _____

Address: _____ City _____ State _____ Zip _____

Date of Birth: _____ / _____ / _____ Phone:(_____) _____ - _____

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

Male: _____ # Female: _____ Total Monthly Household Income: \$ _____

A copy of the first page of your most recent Income Tax Return, or other proof of income, including any source of income (SSI, SSDI, pension, unemployment, alimony, food stamps, etc.,) MUST be included with this application. Failure to include will result in return.

Insurance Information

1. Are you eligible for Medicare? Yes No
2. Are you a veteran of the armed services, or eligible for V.A. benefits? Yes No
3. Do you have any **prescription** coverage? Yes: If yes, please list coverage: _____
(e.g. Medicare, Medicaid, or private prescription insurance) No If NO, How do you pay for your prescriptions? _____

4. Do you have medical insurance? Yes No If NO, How do you pay for your doctor visit ? _____

Patient's Authorization and Certification

By my signature below, I confirm that I am a legal resident of the US and that I understand and that I authorize Lilly Cares, Lilly, and any entity that may be contracted to be the Program administrator of Lilly Cares ("Administrator"), to receive and to have access to the following information: (1) information contained in this application; (2) information on the prescription medications that my Healthcare provider has provided or will provide me; and (3) other information that Lilly Cares, Lilly, or the Administrator may obtain about me in operating and administering the Lilly Cares Program (the "Information").

By my signature below, I further authorize Lilly Cares, Lilly and the Administrator to use the Information in the following manner: (1) to review my application and to contact me or my Healthcare provider, as necessary, to conduct such review; (2) for purposes relating to the operation and administration of the Lilly Cares Program; and (3) for Lilly Cares' and Lilly's internal purposes involving patient assistance programs and charitable programs generally.

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 sending written notice to Lilly Cares at the address set forth on this application. If I revoke this Authorization, I will no longer be eligible for the services provided by the Lilly Cares Program. Canceling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed, but will not affect disclosures made before that time.

I certify that I am not age 65 years or older. I certify that I am neither eligible for Medicare nor currently receiving any benefits under Medicare. I understand that when I turn 65 years old or become eligible for Medicare, I will no longer be eligible for this Program and I agree to promptly notify Lilly Cares of my age and/or eligibility for Medicare at that time. I certify that the information I have set forth in this application is true, correct, and complete and I agree to abide by the rules, procedures and conditions of this program. I understand that eligibility under the Lilly Cares Program is subject to approval by Lilly Cares 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: _____ / _____ / _____

CAUTION: PLEASE COMPLETE ALL SECTIONS OF THIS APPLICATION. AN INCOMPLETE APPLICATION WILL DELAY PROCESSING OF THE REQUEST.