Lilly Cares
Patient Assistance Program
PO Box 230999 ● Centreville, VA 20120
1-800-545-6962 Fax: (703) 310-2534
www.LillyTruAssist.com

About this program: The Lilly Cares Foundation, Inc, a private operating foundation, offers the Lilly Cares Patient Assistance Program to eligible ill and needy US residents who need help in getting select Lilly medications.

Instructions for Application

Can I apply to this program? (You must meet all of these requirements)

- My doctor has prescribed a Lilly drug
- I am a permanent, legal resident of the United States (I do not live outside of the 50 U.S. States.)
- I do **NOT** have prescription drug insurance coverage
- I am **NOT** 65 years of age or older and/or eligible for Medicare, Medicaid, or Veteran's Administration benefits.
- My total GROSS (before deductions) yearly household income is equal to or less than 3 times the Federal Poverty Level. (Visit www.aspe.hhs.gov/poverty for information on Federal\Poverty Level guidelines.)

How do I apply? (Use this checklist)

To make sure your application is not delayed:

YOUR DOCTOR MUST:

- ☐ **Complete the physician sections and sign the Physician Certification section**

THE PATIENT MUST:

- ☐ **Complete each of the patient sections and sign the Patient Certification section.**
- ☐ **Keep a copy of the application and all documents for your records.**
- ☐ **Place application and copies of proof of income together in a stamped envelope and mail to the address listed on the top of this page**

OR

- ☐ **Fax copies of the application and the proof of income to the fax number listed at the top of this page**

What are examples of Proof of Income documents? SEND COPIES ONLY, NO ORIGINALS

- Copy of current pay stubs or earnings statements
- Copy of last year's Federal Income Tax Return
- Copy of Social Security Income Yearly Benefit Statement
- Copy of W-2 or 1099 Form
- Copy of Unemployment Benefit Statement
- Copy of Statements of interest, dividends, or other income

What happens next?

When your application is received it will be reviewed to see if you are eligible for the Lilly Cares program.

- If you qualify, you will be enrolled for 12 months after which you must re-apply. Your medication will arrive at your doctor's office about 4 weeks after your application is approved and you will pick up your medication from your doctor.
- Your doctor must order your medication refills. (Physicians may download the Fax Refill Request form from www.LillyTruAssist.com) or contact Lilly Cares at 1-800-545-6962 for a copy.
- If you do not qualify, your doctor will receive a notice letter stating you are denied enrollment

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Patient Information

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

Date of Birth:_____/_____/_____ Home Phone: _____ Cell Phone :_____

Address:_____

City:_____State:_____Zip:_____

Patient Income Information

Number of People in household (Include ALL family members living in your household): _____

Total Gross Household Monthly Income (Income before deductions): $_____/month

PROOF OF INCOME – SEND COPIES ONLY, NO ORIGINALS – ATTACH CURRENT SOURCES OF INCOME SUCH AS:

- Copy of current pay stubs or earnings statements
- Copy of last year's Federal Income Tax Return
- Copy of Social Security Income Yearly Benefit Statement
- Copy of W-2 or 1099 Form
- Copy of Unemployment Benefit Statement
- Copy of Statements of interest, dividends, or other income

Patient 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 drug coverage (e.g. Medicare, Medicaid, or patient prescription coverage)? ○ Yes ○ No
4. If you do not have prescription coverage, how do you pay for your prescriptions?_____

Patient Certification (You must agree and sign below)

By my signature below, I confirm that I am a 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 health care 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 authorize any pharmacy and/or health care provider who is in possession of my health information to use and/or disclose to Lilly and the Administrator all information relating to my participation in the Program. I understand that if my information is disclosed in this manner by a pharmacy or health care provider federal privacy laws may no longer protect the information from further disclosure.

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**: _____

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Prescriber Information

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

Mailing Address:_____City:_____State:_____Zip:_____

Shipping Address:_____City:_____State:_____Zip:_____
(If different from mailing address – Do not use PO Box – Medication may only be shipped to prescribing provider)

Phone: (_____)_____-_____ Fax: (_____)_____-_____

State License #_____Expiration Date: _____

DEA #_____Expiration Date: _____
(Only for requests of controlled substances)

Medication Information

Patient Name: _____

Product Requested: _____ Dosage:_____
(If prescribing insulin indicate max number of units a day)

Sig:_____Quantity*:_____
*A 4-month supply of most products will be provided unless a lesser amount is requested.

Physician/Prescriber's Attestations and Agreement to Participation 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 "health care provider") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients"). The health care provider agrees to accept the Medications from Lilly Cares and deliver the Medications only to Qualifying Patients at no charge of any kind and further agrees not to use any of the Medications for any other purpose. The health care provider agrees to provide Lilly Cares ninety (90) days advance notice of any proposed assignment, in full or part, of this agreement. 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, I will accept such Medications and 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:_____ **Date**:_____

Original Signature Only; No Photocopies or Stamps