LillyMedicareAnswers Patient Assistance Program
PO Box 66977 ● St. Louis, MO 63166-6977
1-877-RXLilly or 1-877-795-4559 Fax:1-800-692-0331
www.LillyTruAssist.com

Application Form Instructions

Who qualifies for this program?

To qualify, you must meet ALL of the requirements listed below:

- My doctor has prescribed a Lilly drug for me.
- I am a permanent, legal resident of the United States or Puerto Rico
- I am **enrolled in US Medicare Part D or Puerto Rico Medicare Platino**.
- I am denied or not eligible for Low-Income Subsidy (Extra Help) or I have a rejection letter from Medicare Platino
- I am **NOT** enrolled in or eligible for US Medicaid or Puerto Rico's government Health Insurance Plan (Plan de Salud del Gobierno de Puerto Rico)
- My household income is under the Annual Income Limit listed below:

Number of Persons in Your Household	Annual Income Limit *if you live in**		
	Any Other State or D.C.	Hawaii	Alaska
1	$35,310	$40,650	$44,160
2	$47,790	$54,990	$59,760
3	$60,270	$69,330	$75,360
4	$72,750	$83,670	$90,960
5	$85,230	$98,010	$106,560
6	$97,710	$112,350	$122,160
7	$110,190	$126,690	$137,760
8	$122,670	$141,030	$153,360

***Note**: These income limits are 300% of 2015 Federal Poverty Guidelines. You may also visit www.aspe.hhs.gov/poverty for information on Federal/Poverty Level guidelines. Federal Poverty Guidelines may change yearly.

How do I apply?

To apply, complete the following 6 steps:

1. Complete the application and sign the Patient Authorization and Certification.
2. Attach the original prescription your doctor gave you for the medicine.
3. Select and copy appropriate proof-of-income documents. Keep copies for your records.
4. Attach a copy of the **front & back** of your Medicare Part D card.
5. Attach a copy of your Low Income Subsidy denial or rejection letter (US) from Government Health Insurance Plan or Medicare Platino (Puerto Rico) if this applies to you.
6. Put your application, prescription, copies of your current proof of income and Medicare Part D card in a stamped envelope and mail to the address at the top of this application.

What happens next?

- When we receive your application, we will review it to see if you qualify for LillyMedicareAnswers.
- **If you qualify:**
  1. We will enroll you for the remaining days left in this calendar year. After the end of the year, you must apply again if you still need help.
  2. Your medicine will be mailed to your home. Usually this takes about 4 weeks after we get your application.
  3. Your doctor must order your medication refills.

If you have questions about qualifying and applying, please call us at 1-877-795-4559.

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Doctor Information Section

Doctor Name: _____

Address:_____

City:_____State:_____Zip_____

Doctor Phone (____) _____-_____ Fax: (____) _____-_____

Patient Section

Patient Information

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

Address:_____

City:_____State:_____Zip_____

Home Phone (____) _____-_____ Date of Birth:_____/____/_____ Gender: ☐ Male ☐ Female
Month Day Year

List all medicines you are taking right now:_____

_____

List any allergies you may have:_____

_____

Patient Income Information

Number of family members living in your household: _____
(Include yourself, your spouse, all dependents, and anyone living in your house)

If you have any questions, you can call LillyMedicareAnswers at 1-877-795-4559.

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Patient Section-continued

Patient Income Information (continued)

List all gross monthly incomes for everyone in your household (gross income = income before any deductions):

☐ **Salary/wages income**	$
☐ **Social Security income**	$
☐ **Disability income**	$
☐ **Retirement and/or pension income**	$
☐ **Workers' Compensation income**	$
☐ **Unemployment income**	$
☐ **Stocks and bonds income**	$
☐ **Child support/spouse support income**	$
☐ **Any other income not included above**	$
Total gross household monthly income (Add up all boxes above):	$

Proof of income—send copies only, no originals

If you filed taxes last year: ❖ Send a copy of last year's Federal Income Tax Return for yourself, your spouse and all household members (Examples include: IRS Forms 1040, 1040A, 1040EZ, 1040X, 1040NR-EZ, IRS Telefile, 8453, 8879, 1722, Federal Tax Transcript, Federal Recap Form, Hacienda Form 481.0, 482.0, 4506T, 1099 Social Security or Disability Statement)	**If you did not file taxes last year,** ❖ You must send a copy of all that apply: • IRS Form 4506T • All income statements (W-2 or 1099) • Social Security Income Yearly Benefits Statement

If you do not know what to send, you can call LillyMedicareAnswers at 1-877-795-4559.

Please read and sign the following certification:

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Patient Certification (Agreement)

I certify (agree) that the following statements are true:

- I am a legal, permanent resident of the United States or Puerto Rico.
- I **AM** enrolled in Medicare Part D or Medicare Platino.
- I do **NOT** have any medical/health insurance or health benefits other than Medicare Part D.
- I am **NOT** enrolled in or eligible for Medicaid, Disability, Veteran's Administration benefits, or Puerto Rico's Government Health Insurance Plan (Plan de Salud del Gobierno de Puerto Rico).
- My doctor or health care provider has written a prescription for a LillyMedicareAnswers medicine.

I consent to the sharing, use, and receipt of information about me, as described below:

To run LillyMedicareAnswers, Lilly needs some information about you. When you sign below, you understand and you are authorizing Lilly to share, use and disclose your information, and you are authorizing any pharmacy and or health care provider who is in possession of your health information to share information about you that is needed in operating and administering the LillyMedicareAnswers. "Lilly" refers to Lilly, LillyMedicareAnswers, and its business partners contracted to be the Program administrator of LillyMedicareAnswers.

Lilly may receive, share, and use the following information:

- Information in this application.
- Information about my medical conditions, treatment, current & future medicines, and insurance information.
- Other information Lilly may obtain to operate the LillyMedicareAnswers program.
- Lilly may share my information with my health care providers and pharmacists.
- My health care providers and pharmacies may share my information with Lilly.
- Lilly may share my information with the Centers for Medicare and Medicaid Services ("CMS") and /or my Medicare Part D Plan Administrator. This will be consistent with the terms of any Data Sharing Agreement agreed upon by Lilly and CMS or my Medicare Part D Plan.

Lilly may share my information for the following purposes:

- To review my application and to contact me or my health care provider, if necessary, for that review.
- To help operate the LillyMedicareAnswers Program and Lilly's internal purposes involving other patient assistance and charitable programs.
- To my pharmacies and health care providers relating to my participation in LillyMedicareAnswers, including personal information and information about my prescription drugs.

By my signature below, I also agree to the following:

- I understand that my consent lasts for the remainder of the calendar year from the date that I am approved into the program and then I need to apply again to LillyMedicareAnswers.
- I understand that my authorization allows those who rely on it to release my Protected Health Information for the remaining calendar year from the date I signed it.
- I understand that if my information is shared in this manner federal privacy laws may no longer protect my information from further disclosure.
- I understand if I do not sign, refuse to sign, or cancel my authorization, I will not be eligible for LillyMedicareAnswers.

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Patient Certification (Agreement) - Continued

- I understand that I can cancel my consent at any time by sending a written notice to LillyMedicareAnswers at the address on this application. If I cancel my consent, I will no longer qualify for LillyMedicareAnswers. Sharing of my personal information will end after the date that Lilly receives and processes my cancellation letter, but this will not affect information or disclosures shared before that time.
- I agree to follow the rules and conditions of the LillyMedicareAnswers Program & that this is a condition of any assistance provided to me by Lilly.
- I understand that this authorization expires at the end of my participation in the program.
- I have been provided a copy of this authorization.
- I understand that LillyMedicareAnswers will decide if I qualify for this program. I understand that my application might not be approved.
- I will not submit any claim for reimbursement to any third party insurer for any product provided to me under the LillyMedicareAnswers program.
- I will not claim any true-out-of-pocket-cost (“TrOOP”) from my Medicare Part D Plan for the value of the product given to me under LillyMedicareAnswers.
- I understand that it is my responsibility to let my Medicare Part D Plan know about my enrollment in the LillyMedicareAnswers Program.
- I understand the LillyMedicareAnswers program may change or end at any time without advance notice.
- I understand and agree that if Lilly asks, I will provide documentation that proves the information I have certified in this application is true, correct, and complete.
- I wish to enroll in the LillyMedicareAnswers Program.

Patient or Legal Guardian Signature: _____Date: _____