Hours of Operation: Monday through Friday 9 AM to 7 PM ET

Address: PO Box 12207 La Jolla, CA 92039

Phone: 1-866-472-8663

Fax: 1-877-366-0585

# Important Information on Available Support

- Reimbursement Support is for ALIMTA® (pemetrexed for injection), CYRAMZA® (ramucirumab), ERBITUX® (cetuximab), LARTRUVO™ (olaratumab), and Portrazza® (necitumumab) only.
- The Lilly PatientOne Co-pay Program is available only for ALIMTA, CYRAMZA, ERBITUX, LARTRUVO, and Portrazza when administered for an FDA-approved indication.
- The Lilly Cares Foundation, Inc., an independent nonprofit organization (the "Lilly Cares Foundation"), helps eligible patients who cannot afford the Lilly medications listed in Section 1 through its patient assistance program (the "Lilly Cares Foundation Patient Assistance Program").

# 3-Step Registration

## Step 1 - Complete the Application

- Check the box in section 1 for all support requested (note that we will contact you if we find that your patient may need or may qualify for other support offered in this application).
- Be sure to complete the physician and patient information sections.
- If you are applying for the Lilly Cares Foundation Patient Assistance Program, please be sure to complete section 6 and **include the appropriate financial documentation. Examples of acceptable financial documents include, but are not limited to, one of the following: copy of last year's federal income tax return; copy of current pay stub or earnings statement; copy of Social Security income yearly benefit statement; copy of W-2 or 1099 Form; Tax Summary Letter.**
- Please be sure to complete section 7 for the Lilly Cares Foundation Patient Assistance Program.

## Step 2 - Read and Sign

- **IMPORTANT: A completed Patient Agreement and Consent (attached) must be signed and submitted before patient-specific research can begin.**
- Please ensure the physician and patient read and sign appropriately for the services being requested.
- Please have the patient read and sign the Lilly PatientOne Co-pay Program Terms and Conditions portion if applying for the PatientOne Co-pay Program.
- Please remember to include a copy of the insurance cards where applicable.
- Stamped signatures or signatures by persons other than the prescribing healthcare physician are not acceptable.

## Step 3 - Fax the Application

- **Fax the completed application and any supporting documents to 1-877-366-0585. We recommend that you return the completed form via fax in order to expedite the process.** Once the application is received, we will notify the physician's designated office contact (in section 2 ) of the results.

Incomplete or incorrect information may delay the process, so please ensure all information is provided correctly and signatures are obtained.

**Should you have any questions, please call 1-866-4PatOne (1-866-472-8663).**

**A PatientOne Specialist will be in touch with you very soon with the results.**

## 1 SUPPORT REQUESTED

☐ Reimbursement Assistance
Benefit Investigation, Prior Authorization, Claims Assistance

**ALIMTA®** (pemetrexed for injection)
**CYRAMZA®** (ramucirumab)
**ERBITUX®** (cetuximab)
**LARTRUVO™** (olaratumab)
**Portrazza®** (necitumumab)

FDA-approved and Compendia use only

☐ Lilly Cares Foundation Patient Assistance Program
Product Replacement or Proactive Provision for Qualified Patients

**ALIMTA®** (pemetrexed for injection)
**CYRAMZA®** (ramucirumab)
**ERBITUX®** (cetuximab)
**GEMZAR®** (gemcitabine)
**LARTRUVO™** (olaratumab)
**Portrazza®** (necitumumab)

FDA-approved and Compendia use only

☐ Lilly PatientOne Co-pay Program
For Qualified Commercially Insured Patients

**ALIMTA®** (pemetrexed for injection)
**CYRAMZA®** (ramucirumab)
**ERBITUX®** (cetuximab)
**LARTRUVO™** (olaratumab)
**Portrazza®** (necitumumab)

FDA-approved use only

## 2 PHYSICIAN INFORMATION

Facility Name _____ Facility NPI _____

Physician's Name _____ Physician's NPI _____

Physician's State License _____ Physician's Tax ID _____ Physician's PTAN _____

Physician's Medicaid ID _____ Address _____

City _____ State _____ ZIP _____

Office Contact _____ Phone Ext _____ Fax _____

## 3 PATIENT INFORMATION

Patient's Name (First, MI, Last) _____ Gender M/F _____

Address _____

City _____

State _____ ZIP _____

Home Phone Number** _____ Cell Phone** (Optional) _____

DOB _____

** By providing my home/cell phone number and signing this form, I consent to receive automated (and/or prerecorded) calls and/or texts about Reimbursement Support, the Lilly PatientOne Co-pay Program, and/or the Lilly Cares Foundation Patient Assistance Program at this number. I understand that I am not required to provide this number to participate in the programs, but if I do not then I will not be able to receive certain status reminders and other program communications.

## 4 TREATMENT INFORMATION

Treatment Setting:
☐ Physician's Office ☐ Hospital Outpatient

Name and Address of Hospital (if applicable)

_____

Hospital NPI (if applicable) _____ Hospital Tax ID (if applicable) _____

Product Prescribed:
O ALIMTA
O CYRAMZA
O Portrazza
O ERBITUX
O LARTRUVO
O GEMZAR (for PAP only)

Start Date _____

Diagnosis (ICD-10) Code _____

RAS Tested? (ERBITUX only) ☐ Yes ☐ No Results _____

Will the prescribed product be ordered directly from a specialty pharmacy? ☐ Yes ☐ No

## 5 INSURANCE INFORMATION Please include Medicare, Medicaid, and/or other government plans. Please provide copies of all insurance cards (front/back).

**Primary Insurance:**

Insurance Name _____ Telephone _____

Policy Holder Name _____ Policy ID # _____ Group ID # _____

**Secondary Insurance:**

Insurance Name _____ Telephone _____

Policy Holder Name _____ Policy ID # _____ Group ID # _____

## 6 COMPLETE THIS SECTION FOR LILLY CARES FOUNDATION PATIENT ASSISTANCE PROGRAM

Adjusted Gross Household Income _____ ○ yearly ○ monthly # in Household _____

Please submit at least one copy showing your proof of income with this application. Examples of acceptable documents include, but are not limited to: copy of last year's federal income tax return; copy of current pay stub or earnings statement; copy of Social Security income yearly benefit statement; copy of W-2 or 1099 Form; Tax Summary Letter.

## 7 PRESCRIPTION INFORMATION (Complete this section for Lilly Cares Foundation Patient Assistance Program only)

☐ **Product Replacement** - Request product after dose has been administered

☐ **Product Provision** - Request product prior to administration

Date _____

Patient Name _____ DOB _____

Product Requested _____ Vial Size _____ # of Vials _____

Dosage _____ Dosing Schedule/Frequency _____

Scheduled Administration Dates _____

**Prescriber Signature** _____ _____

Dispense as Written Substitution/Brand Exchange Permitted

Prescriber Signature: Prescriber must manually sign (Rubber stamps, signature by other office personnel for the prescriber and computer-generated signatures will not be accepted).

**Please proceed to the next pages for IMPORTANT INFORMATION AND AUTHORIZATION SECTION**

## Physician Acknowledgment

**By signing the below, I certify:**

- The information provided is accurate to the best of my knowledge
- The therapy is medically necessary. I also represent that I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient, to Eli Lilly and Company, the Lilly Cares Foundation, Inc., Lilly USA, LLC and their vendors, business partners, and agents (the "Program Representatives") for the purpose of assessing whether the patient qualifies for Reimbursement Support, the Lilly PatientOne Co-pay Program or the Lilly Cares Foundation Patient Assistance Program through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Program Representatives so that Program Representatives may contact the patient to further enable these services
- I am licensed, will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the state in which I am prescribing, receiving, storing, and dispensing the medication identified on this application to the patient listed in this application and prescribed the medication to this patient based on my independent clinical judgment that treatment with this medicine for this patient is medically necessary

**Lilly Cares Foundation Patient Assistance Program or Lilly PatientOne Co-pay Program**

- Treatment for patients enrolled in the *Lilly PatientOne Co-pay Program is for an FDA-approved indication*
- Treatment for patients enrolled in the *Lilly Cares Foundation Patient Assistance Program is for FDA-approved indication and/or Compendia use*
- To the best of my knowledge the patient meets the financial, insurance, and residency requirements of the Lilly Cares Foundation Patient Assistance Program or the Lilly PatientOne Program, as applicable. For the Lilly Cares Foundation Patient Assistance Program, patients must be permanent, legal US residents. If I am aware the patient no longer meets the criteria for the applicable program, I agree to immediately notify the appropriate Program Representative
- I have not received and will not seek reimbursement or payment for all or any part of the benefit received by the patient through the applicable program
- Any medication provided by the Lilly Cares Foundation Patient Assistance Program for this patient through any of the programs in this application will not be resold, nor offered for sale, trade or barter, or returned for credit
- The payer's required number/level of appeals have been completed for a Lilly Cares Foundation Patient Assistance Program applicant and I have received denials on each of those appeals

**I understand:**

- Lilly USA, LLC, or the Lilly Cares Foundation as appropriate, may change, terminate, suspend participation, limit enrollment, or recall/discontinue medications in the program without prior notice
- I am under no obligation to purchase or prescribe any Lilly drug to participate in these programs and I have not received nor will I receive any benefit from any Program Representatives for prescribing a Lilly drug
- Program Representatives are not responsible for filing any insurance claim
- The information provided will be subject to potential random reviews
- If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, the Lilly Cares Foundation will bill for the covered product, and I agree to be responsible for payment of the bill
- If I elect to receive medication through the Lilly Cares Foundation Patient Assistance Program under the Proactive Provision program, I certify that I will complete the required Administration Verification form confirming that the free product has been administered to the applicable enrolled patient. I will notify the Lilly Cares Foundation Patient Assistance Program if any free product is not administered to the applicable enrolled patient and will return the product to the Lilly Cares Foundation Patient Assistance Program for destruction or appropriately destroy the product at the facility and submit documentation to the Lilly Cares Foundation Patient Assistance Program confirming that the product has been appropriately destroyed. If I do not return or destroy the free product provided and not used for the applicable enrolled patient, I will be billed for the product and I agree to be responsible for payment of the bill. Please contact Lilly PatientOne at 1-866-472-8663 for assistance with product returns.

**Original Signature of PHYSICIAN** _____ **Date** _____

# Patient Agreement and Consent

- PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL US AT 1-866-472-8663. YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.
- Reimbursement Support and the Lilly PatientOne Co-pay featuring ALIMTA, CYRAMZA, ERBITUX, LARTRUVO, or Portrazza Program are available free of charge from PatientOne, a patient support program offered by Lilly USA, LLC ("PatientOne") (Reimbursement Support and the Lilly PatientOne Co-pay Program are collectively referred to as the "PatientOne Support Programs"). If you don't have a healthcare plan, or your healthcare plan won't pay for your prescribed Lilly treatment and you meet certain financial and medical standards, we will work with you and your physician(s) to identify possible sources of reimbursement. One such program provided free of charge to eligible patients is the Lilly Cares Foundation Patient Assistance Program, which is provided by the Lilly Cares Foundation Inc., an independent nonprofit organization ("Lilly Cares") that helps eligible patients obtain certain medications listed in this application free of charge. PatientOne collects information on behalf of Lilly Cares to assist Lilly Cares with its charitable mission.
- I understand that I am submitting this application or my doctor's office is submitting it on my behalf, to see if I qualify for financial assistance with my Lilly medications as part of the PatientOne Support Programs or the Lilly Cares Foundation Patient Assistance Program. I understand that before PatientOne can assist me, PatientOne may need to collect, use, and disclose information about me that is requested on this application, including my Protected Health Information ("PHI"), my financial information (for example, my Social Security Number) and other personal information about me (collectively "My Personal Information"). PHI that will be disclosed includes any information related to my healthcare insurance or plan benefits, including coverage limits and other information related to my health and treatment, including possible sensitive material relating to sexually transmitted diseases, mental health conditions, and/or genetic testing; as well as any information that has a bearing on my health or whether I'm staying on my medicine or treatment. Although PatientOne is not looking for PHI that is unrelated to my Lilly treatment, it may be part of the health records sent to it.
- I understand that by signing this form, I am permitting my doctor's office, my healthcare plan or insurance company, my pharmacies, as well as other entities that may hold my PHI, to release My Personal Information, including my PHI, to Eli Lilly and Company, Lilly USA, LLC, Lilly Cares, and to their vendors, business partners and agents who may be assisting with the administration of the PatientOne Support Programs or the Lilly Cares Foundation Patient Assistance Program ("Program Representatives"). I understand that to provide the services for the PatientOne Support Programs, and the Lilly Cares Foundation Patient Assistance Program, the Program Representatives may need to further disclose My Personal Information to and communicate with other Program Representatives involved with the PatientOne Support Programs or the Lilly Cares Foundation Patient Assistance Program, my doctor's office or other healthcare providers, including my insurance company or health plan or pharmacies.
- I attest that I am a permanent, legal US resident (If applying for the Lilly Cares Foundation Patient Assistance Program).
- I further understand that the Program Representatives will use My Personal Information in the following manner: (1) to review my application for any of the PatientOne Support Programs and/or the Lilly Cares Foundation Patient Assistance Program, and to help determine my healthcare plan coverage for Lilly medications prescribed by my doctor and other procedures as part of my therapy on Lilly medications; (2) to contact me or my doctor's office or other of my healthcare providers, as necessary, to conduct such services; (3) for purposes relating to the operation and administration of the PatientOne Support Programs and/or the Lilly Cares Foundation Patient Assistance Program, including measuring and tracking the quality of the services, and the consideration of assistance possible in other Lilly Patient support programs, or to make me aware of alternative sources of funding and programs, including third-party nonprofit organizations and programs; and (4) track my use of prescribed Lilly treatments. I also understand that the Program Representatives can contact me to collect any additional information needed to provide these services to me.
- **I understand that I do not have to sign this consent,** but if I do not, I will not receive the described services. I understand that I might need to pay for my Lilly medication on my own, whether I sign this form or not. I understand that once my doctors, healthcare plan, pharmacies, or others who have my PHI release it, my information may no longer be covered by Federal and State Privacy Law (for example, HIPAA).

  This authorization allows those who rely on it to release my PHI for 1 year from the date I have signed it. I understand that I can withdraw it at any time by sending a written notice to Patient One PO Box 12207, La Jolla, CA 92039. My withdrawal goes into effect once it is received by the PatientOne Support Programs and/or the Lilly Cares Foundation Patient Assistance Program, as applicable. I also understand that by withdrawing, I may not receive or I may stop receiving the services provided under the PatientOne Support Programs and/or the Lilly Cares Foundation Patient Assistance Program.

**PATIENT or Legal Guardian Signature**

_____ **Date** _____

**Printed Name of Patient or Legal Guardian** _____

# Lilly PatientOne Co-pay Program Terms and Conditions (Effective June 1, 2017)

**Eligibility:**
(1) You have been prescribed one of the following Lilly Oncology medicines covered by the Lilly PatientOne Co-pay Program ("Program"): Alimta® (pemetrexed for injection), Cyramza® (ramucirumab), Erbitux® (cetuximab), Portrazza® (necitumumab), or Lartruvo™ (olaratumab) (hereinafter collectively referred to as "prescribed Lilly Oncology medicine"). (2) You have commercial insurance that covers your prescribed Lilly Oncology medicine, but your insurance does not cover the full cost; that is, you have a co-pay or coinsurance obligation. (3) You are not participating in any state or federal healthcare program, including, without limitation, Medicaid, Medicare, Medigap, CHAMPUS, DOD, VA, TRICARE, or any state patient, or pharmaceutical assistance program; patients who move from commercial insurance to a state or federal healthcare program will no longer be eligible. (4) You are 18 years of age or older and are receiving your prescribed Lilly Oncology medicine for an FDA-approved use. Please ask your doctor for information about FDA-approved uses. Also see your doctor for the full US Prescribing Information for your prescribed Lilly Oncology medicine. (5) You are a resident of the United States or Puerto Rico.

**Program Benefits:**
(6) The patient must first pay a portion of his or her co-pay or coinsurance ($25 for each dose of the patient's prescribed Lilly Oncology medicine). The Program will cover the remainder of the patient's co-pay or coinsurance for the prescribed Lilly Oncology medicine, up to a maximum of $25,000 during a 12-month enrollment period. (7) In order to receive Program benefits, the patient or healthcare provider must submit an Explanation of Payment (EOP) form. The submitted form must include the name of the insurer and plan, and show that the prescribed Lilly Oncology medicine was the medication that was administered. (8) For enrolled patients, a claim for reimbursement must be submitted within 180 days of infusion to receive Program benefits. (9) Program benefits are limited to the co-pay or coinsurance costs for doses of the prescribed Lilly Oncology medicine only. The Program will not cover, and shall not be applied toward, the cost of any dosing procedure, any other healthcare provider service or supply charges or other treatment costs, or any costs associated with a hospital stay. (10) For enrolled patients, the Program may provide support for doses with a date of service that falls within 120 days prior to the date the application is received by the Program.

**Program Timing:**
(11) Patients must enroll on or before December 31, 2018, to be eligible to receive benefits. (12) If you live in Massachusetts, the Program co-pay card expires on the earlier of: (i) the expiration date of the Program co-pay card (December 31, 2018): (ii) the date an AB rated generic equivalent becomes available; or (iii) June 30, 2019, absent a change in Massachusetts state law.

**Additional Program Terms and Conditions:**
(13) Patients, pharmacists, and healthcare providers must not seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this Program. Patients must not seek reimbursement from any health savings, flexible spending, or other healthcare reimbursement accounts for the amount of assistance received from the Program. (14) Acceptance of this offer confirms that this offer is consistent with your insurance and that you will report the value of the co-pay assistance you receive as may be required by your insurance provider. (15) This offer is not valid with any other financial support program, Patient Assistance Program (PAP), discount, or incentive involving the prescribed Lilly Oncology medicine. (16) Only valid in the United States and Puerto Rico; this offer is void where restricted or prohibited by law. (17) The Program benefits are nontransferable. (18) This offer is not conditioned on any past, present, or future purchase, including additional doses. (19) The Program is not insurance. (20) Lilly USA, LLC reserves the right to terminate, rescind, revoke, or amend this offer at any time without notice.

**By signing below, I certify that I have read and accept the Lilly PatientOne Co-pay Program Terms and Conditions.**

**PATIENT or Legal Guardian Signature**

_____ **Date** _____

## Additional Services Patient Authorization

In addition to the services I have authorized above, I understand that Eli Lilly and Company and/or Lilly USA, LLC ("Lilly") also offer certain free patient services and product programs related to my Prescribed Lilly Oncology Medicine. I would like to take part in these programs and understand that these services are optional and my decision to participate or not in these additional programs will not impact the services I have authorized above. In order for me to receive these additional patient program services from Lilly, Lilly needs this separate consent to receive and use my Protected Health Information for these programs. I understand that these services may include communicating with me by mail, email, and phone and that such communications may include marketing materials and offers for product training and support, or other services that may become available, or requests from Lilly for my participation in market research. I also understand that Lilly may share information from my participation in these programs with my healthcare provider. To withdraw my consent, I understand that I must contact the Program in writing at the address above. My withdrawal goes into effect once it is received by the Program. By signing below, I consent to these services and certify that I am at least eighteen (18) years of age.

**PATIENT or AUTHORIZED REPRESENTATIVE Signature**

_____ **Date** _____