LillyMedicareAnswers Patient Assistance Program

PO Box 66977
St. Louis, MO 63166-6977
1-877-RXLilly or 1-877-795-4559

- This blank form may be copied.
- Eli Lilly and Company ("Lilly") provides a patient assistance program that supplies certain medications to qualifying residents who need temporary assistance in obtaining their Lilly medications.
- To apply for this program, the patient must submit a completed application with required documentation, meet certain eligibility criteria, and reapply yearly.
- If the patient is enrolled, the first medication shipment will arrive within approximately 2 weeks after the application is received. If not enrolled, all documentation is returned to the patient.
- NOTE: Patients must be enrolled in a Medicare Part D Program. For information or help, patients may call 1-800-MEDICARE or visit www.medicare.gov.
- Eligible patients cannot receive assistance from US Medicaid, or Puerto Rico's Government Health Insurance Plan or Medicare Platino

Please print clearly and complete all blanks

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Step 1 - Physician Information			
Physician Name:	Phone: ( )	Fax: ( )	
Address:	City:	State:	Zip:

Step 2 - Prescription Information: **valid prescription(s) must be attached with the application. Note: injection supplies require a valid prescription.**

Step 3 - Patient Information			
Patient Name:		SS#: - -	
Street Address:		Date of Birth: / /	Male ☐ Female ☐
City:	State:	Zip:	Phone: ( )
Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 greater than 7	Legal Resident? Yes ☐ No ☐	Do you receive disability benefits? Yes ☐ No ☐	Do you receive Veteran's Admin benefits? Yes ☐ No ☐

Financial Information Note: You must attach a copy of your most recent US Income Tax Return (ie, IRS Form 1040, 1040A, 1040EZ, 1099).

List All Sources of Gross Monthly Amounts

Salary/Wages $_____ Social Security $_____ Child Support/Alimony $_____

Disability $_____ Pension/ Retirement $_____ Unemployment/ Work Comp $_____

Total Gross Household Monthly Income: $_____

List your monthly Interest/Earnings from **Assets**:

$_____

Private Drug Coverage	**US Medicaid – or – Puerto Rico Plan de Salud del Gobierno – or – Medicare Platino**	**Medicare Part D**
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

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Important Instructions: Patients must submit:

- **In US, a Low-Income Subsidy (Extra Help) denial letter if their income is 135% of the Federal Poverty Level or below based on household size.**
- **In Puerto Rico, a rejection letter from Government Health Insurance Plan or Medicare Platino (if applicable**

All patients must submit a copy of the front and back of their Medicare Part D Prescription Drug Plan Card. Patients also must complete the Medicare Part D Prescription Drug Plan and Consent sections below.

Medicare Part D Prescription Drug Plan Information

Prescription Drug Plan Name:		Group Code Number:
Prescription Drug Plan Phone Number:		
Prescription Drug Plan Address:		
City:	State:	Zip:

Step 4 – Patient Authorization and Certification (Patient must sign below)

By my signature below, I confirm that I wish to enroll in the LillyMedicareAnswers program the ("Program"), and my signature below certifies that fact along with certifying the factual accuracy of the statements set forth below:
I am a legal resident of the US; the information I have set forth below is true, correct, and complete; and I agree to abide by the rules, procedures, and conditions of this Program. I am NOT eligible for Medicaid. I am enrolled in a Medicare Part D Plan, AND my physician or other healthcare provider has prescribed a Lilly medication covered in this Program. By signing this form I hereby certify and agree that: (i) I will not submit any claim for reimbursement to any third party insurer, including my Medicare Part D Plan, for any product provided to me under LillyMedicareAnswers program. I am not eligible for Puerto Rico's Government Health Insurance Plan or Medicare Platino. I understand and agree to provide to Eli Lilly and Company ("Lilly"), upon Lilly's request, supporting documentation that verifies the assertions that I have certified to in this form. I acknowledge that my compliance with this certification is a condition of any assistance provided to me by Lilly.
I will not claim true-out-of-pocket-cost ("TrOOP") from my Medicare Part D Plan for the value of the product provided to me under LillyMedicareAnswers and I understand that it is my responsibility to notify my Medicare Part D Plan of my enrollment in the LillyMedicareAnswers program. I hereby authorize the Administrator and/or Lilly to share data with the Centers for Medicare and Medicaid Services ("CMS") and/or my Medicare Part D Plan consistent with the terms of any Data Sharing Agreement agreed upon by Lilly and CMS or my Medicare Part D Plan. I understand that Lilly and any entity it may contract with to be the administrator for this Program (referred to as the "Administrator") will receive the information contained in this form, information on the prescription medicines that my prescriber has provided or will provide me, information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the Program, any information or data related to the Program from the date of my enrollment in the Program, any of my personal information and other information that they may obtain about me in appropriately operating and administering this program (the "Information"). I hereby authorize the Administrator and/or Lilly to use and/or disclose the Information: (i) to review my eligibility and contact me, and/or my healthcare provider, as necessary to conduct such review and to keep me and my healthcare provider apprised of my enrollment status; (ii) for purposes relating to the operation and administration of this Program; and (iii) for Lilly's internal business purposes involving patient assistance programs generally. I authorize any pharmacy to use and/or disclose to Lilly all Information relating to my participation in the Program. I understand that if my Information is disclosed, federal privacy laws may no longer protect the Information from further disclosure. I understand that I have the right to revoke this Authorization at any time by writing Lilly at the address set forth on this form. If I revoke this Authorization, I will no longer be eligible for the Program. Canceling this Authorization will prohibit disclosures of my Information after the date the cancellation letter is received and processed, but will not affect disclosures made before that time. This Authorization expires at the end of my participation in the Program. I acknowledge that I have been provided a copy of this Authorization. Other than a Medicare Part D Plan, I do not have any government or private insurance that covers or helps me pay for my medications.
I understand that the Program described herein may be changed or terminated at any time without prior notice.

Patient's Signature:_____	Date:_____
Personal Representative:_____	Date:_____
Relationship to the Patient:	

APPLICATION CHECKLIST:

- COMPLETE ALL BLANKS – MISSING INFORMATION WILL CAUSE A DELAY IN PROCESSING!
- INCLUDE Prescription(s)
- INCLUDE financial copies
- INCLUDE copy of Medicare card, both front and back
- SIGN CERTIFICATION