Lilly Oncology
Support Center

# **Infused Products** Enrollment Form



Please complete and fax this form to **1-877-366-0585**

**If you have any questions, please call the Lilly Oncology Support Center™ at 1-866-472-8663, Monday-Friday 8am-10pm EST**

By enrolling in the Lilly Oncology Support Center, Patients may receive various forms of support and information to help access infused oncology products, which may include the following:

- Benefits Investigation Support
- Copay Savings and Other Financial Support
- Ongoing Support

**In order to process the requested services, the Lilly Oncology Support Center will require 2 Patient signatures and 1 Prescriber signature. If the Patient is requesting a Lilly Oncology Infused Products Savings Card, we will require another Patient signature accepting the Savings Card Terms and Conditions. Not signing this form will result in an incomplete submission and a delay in requested services.**

## Patient Enrollment Checklist:

**Page 2**

- ☐ Complete all sections in the Patient Enrollment section
- ☐ Document insurance information or provide copies of your insurance and prescription card(s)
- ☐ Select optional Lilly Oncology Support Center services that you would like to receive

➔ **Be sure to sign and date where "Signature of Patient" is located**

**Page 3**

➔ **Read and sign Patient HIPAA Authorization**

**Pages 5-7**

- ☐ Read and acknowledge the consent, terms and conditions, and privacy notice on remaining pages

➔ – *If requesting a Lilly Oncology Infused Products Savings Card, please sign page 6 accepting the terms and conditions*

## Prescriber Enrollment Checklist:

**Page 4**

- ☐ Complete all sections in the Prescriber Enrollment section
- ☐ Complete the prescription section, including: treatment setting, diagnosis code, product prescribed, and start date
- ☐ Select Benefits Investigation and Field Reimbursement Support OR Field Reimbursement Support Only
  - *If selecting Field Reimbursement Support Only, indicate which specialty pharmacy or institution the prescription should be sent to*

➔ **Manually sign and date the form**

Complete and fax this form to **1-877-366-0585**

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# PATIENT ENROLLMENT SECTION Infused Products

**OFFICE: Please fax to 1-877-366-0585**



Patient

**Patient Name** (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

**Address** _____ **City** _____ **State** _____ **ZIP Code** _____

**US or Puerto Rico Resident** ☐ Yes ☐ No **Gender** ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other_____

**Phone*** _____ **Email** _____

*By providing my telephone number and signing this form, I agree to receive automated marketing calls and texts from and on behalf of Eli Lilly and Company. I understand that I am not required to provide my number as a condition of purchase. Message and data rates may apply.

**Signature of Patient** _____ **Date (MM/DD/YYYY)** _____

*Not signing this form will result in an incomplete submission and a delay in requested services*

**Must select one of the following:** ☐ **No Insurance Coverage** ☐ **Copy of Policyholder's Insurance Card (front and back) is attached** ☐ **Provide Information Below**

**Primary Prescription Insurance Company** _____

**Insurance Company Phone #** _____ **Cardholder Name** _____

**Policy/ID** _____ **Group #** _____

**RX BIN** _____ **PCN** _____

☐ No ☐ Yes **Do you use government insurance to fill your prescriptions? Examples include Medicaid, Medicare, Medicare Part D, TRICARE®, and others.**

☐ I would like to request a **Lilly Oncology Infused Products Savings Card** and agree to the Savings Card Terms and Conditions on pages 5-6

☐ I would like **Lilly Oncology Support Program Ongoing Support** and agree to the Optional Lilly Oncology Support Program Ongoing Support Enrollment Consent on page 6

I understand I am enrolling in the Lilly Oncology Support Center to help facilitate access to my prescribed medication. By checking the corresponding optional boxes above, I consent to my enrollment in the additional Lilly Oncology Support Center services as described in the Consent on page 6. To cancel your participation in the program, please contact us at **1-866-472-8663.**

Lilly Oncology
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# PATIENT HIPAA AUTHORIZATION

**OFFICE: Please fax to 1-877-366-0585**



Before the Lilly Oncology Support Center can start helping you, Lilly may ask for some information about you and your health. This is known as your *Protected Health Information, or PHI.* By signing this form, you understand and agree that your PHI may be shared with or used by Lilly as explained below.

**PHI includes information like:**

- Your health insurance or benefits, including how much coverage you have
- All records about your treatment
- Whether you're staying on your medicine or treatment
- Anything that affects your health

**If you agree, your PHI may be shared by:**

- Your doctors and other healthcare providers
- Your healthcare plan or health insurance company
- Clearinghouses or other agents
- Your pharmacy
- Others who might have your PHI

**Your PHI is used in ways like these:**

- To learn how much of your Lilly treatment is covered by your insurance
- To help you find other ways to afford your treatment
- To track your use of your Lilly treatment
- To share information with your healthcare provider
- To make sure that you receive high-quality services from the program
- To measure program performance and make program improvements
- Internal Lilly use of data to drive business decisions and metrics on hub performance
- Reports to our sales force regarding HCP use of hub services
- Conversations/messages to your HCP regarding trends and hub performance

**Other things you should know about sharing and using your PHI:**

- We only ask for and share the PHI that we need to provide the benefits you want. We do not ask for any PHI that we do not need, but we may receive some in the health records sent to us. Your PHI will be released to Eli Lilly and Company and Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "Lilly")
- You don't have to give permission to share your PHI with Lilly to receive treatment from your healthcare providers, your prescription from your pharmacy, or benefits from your healthcare plan, but the Lilly Oncology Support Center may not be able to help you without it
- After your PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again
- Your signed permission to share and use your PHI lasts for 3 years from the date of your signature unless you are a resident of Maryland, Maine, or Montana, in which case the permission will last for 1 year from the date of your signature. In either case, you may revoke your permission before then by writing to PO Box 12307, La Jolla, CA 92039, which will preclude reliance on the authorization after the date your written revocation is received
- Your healthcare providers (such as pharmacies) may be paid by us in exchange for sharing your PHI. They may also be paid by us to use your PHI to provide services, such as contacting you about Lilly products

**If you would like to opt out of the program or make changes to your enrollment:**

- You can stop sharing your PHI with us or change what you share by calling us at **1-866-472-8663**, or by writing us at PO Box 12307, La Jolla, CA 92039

**I have read and agree to the Patient HIPAA Authorization**

**Signature of Patient** _____ **Date (MM/DD/YYYY)** _____

*Not signing this form will result in an incomplete submission and a delay in requested services*

Lilly Oncology Support Center

# PRESCRIBER ENROLLMENT SECTION Infused Products

**OFFICE: Please fax to 1-877-366-0585**



## Prescriber

**Name** (First, Last) _____ **NPI #** _____

**Practice Name** _____ **Phone** _____ **Fax** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Group Tax ID** _____ **Office Contact Name** _____ **Office Contact Phone** _____

**Collaborating Physician** _____ **NPI #** _____

## Patient

**Patient Name** (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

***Valid enrollment includes: Treatment Setting, Diagnosis Code, Product Prescribed, and Start Date***

**Treatment Setting:** ☐ **Physician's Office** ☐ **Hospital Outpatient**

**Name and Address of Hospital** (if applicable) _____

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

**You must enter a diagnosis**

| **Diagnosis Code** (ICD-10) | **Product Prescribed: PLEASE SELECT ONLY ONE PRODUCT PER FORM** | **Start Date** |
|---|---|---|
| _____ | ☐ **ALIMTA** ☐ **CYRAMZA** ☐ **ERBITUX** ☐ **Portrazza**<br>**[RAS Tested?** ☐ **YES** ☐ **NO]** **Results** _____ | _____ |

☐ **Benefits Investigation and Field Reimbursement Support** – (FDA-Approved and Compendia Use) The Lilly Oncology Support Center will research the Patient's insurance options to help identify the lowest out-of-pocket cost available for the prescribed medication. A Lilly Oncology Support Center representative will help triage and troubleshoot access issues on the Patient's behalf. This includes Prior Authorization and Appeals Research. **IF CHECKED, MUST FILL OUT SECTION ABOVE.**

☐ **Savings Card Program Support** – For Qualified, Commercially Insured Patients Only – (FDA-Approved Use Only) **IF CHECKED, PATIENT MUST REQUEST A SAVINGS CARD ABOVE AND PROVIDE THEIR SIGNATURE ACCEPTING THE SAVINGS CARD TERMS AND CONDITIONS FROM PAGE 5.**

Specialty pharmacy or institution where prescription was sent _____

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to Eli Lilly and Company, its affiliates, agents, representatives, business partners, and service providers (together "Lilly") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to Lilly so that Lilly may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support Lilly provides; 5) I am licensed to prescribe the prescription medication identified in this form; 6) Treatment for Patients enrolled in the Lilly Oncology Infused Products Copay Program is for an FDA-approved indication; and 7) to the best of my knowledge, the Patient meets the insurance and residency requirements (for those applying for the Lilly Oncology Infused Products Copay Program). **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE.** Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

**PRESCRIBER SIGNATURE:**

_____ _____

**Prescriber Signature** **Date (MM/DD/YYYY)**

*Not signing this form will result in an incomplete submission and a delay in requested services*

# SAVINGS CARD TERMS AND CONDITIONS



## Lilly Oncology Infused Products Co-pay Program Terms and Conditions:

By using the Lilly Oncology Infused Products Co-pay Program, you attest that you meet the eligibility criteria, agree to and will comply with the terms and conditions described below.

### Eligibility:

(1) You have been prescribed one of the following Lilly Oncology medicines covered by the Lilly Oncology Infused Products Co-pay Program ("Program"): Alimta® (pemetrexed for injection), Cyramza® (ramucirumab), Erbitux® (cetuximab), or Portrazza® (necitumumab) (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 monthly cap of wholesale acquisition cost plus usual and customary fees and 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, 2020 to be eligible to receive benefits. The savings card program expires on December 31, 2021. Patients must first use their card by December 31, 2020 and are eligible for savings for up to 12 months of therapy, provided they continue to meet program terms and conditions. (12) If you live in Massachusetts, the Program co-pay card for your prescribed Lilly Oncology medicine expires on the earlier of: (i) The expiration date of the Program co-pay card (December 31, 2021); (ii) The date an AB rated generic equivalent becomes available; or (iii) December 31, 2020, absent a change in Massachusetts state law. If you live in California, the card for your prescribed Lilly Oncology medicine expires on the earlier of: (i) The expiration date of Program co-pay card (December 31, 2021); or (ii) The date an FDA-approved therapeutically equivalent becomes available or over-the-counter product with the same active ingredients becomes available.

**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, discount card, cash discount card, coupon 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. Program expires December 31, 2021.

**By signing below, I certify that I have read and accepted the Lilly Oncology Support Center Savings Card Program Terms and Conditions**

**Signature of Patient** _____ **Date (MM/DD/YYYY)** _____

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**What to Know About The Lilly Oncology Support Center Ongoing Support Program:**

Your healthcare provider has talked with you about using Eli Lilly and Company oncology medicines. The Lilly Oncology Support Center was created to help you have a positive experience as you get started with and use these medicines. The Lilly Oncology Support Center offers personalized support to Patients at no charge.

**OPTIONAL LILLY ONCOLOGY SUPPORT CENTER ONGOING SUPPORT ENROLLMENT CONSENT**

**Ongoing Support Enrollment Consent:**

The Ongoing Support Services included in the Lilly Oncology Support Center provide support after you've received your medication, like check-in calls to answer any questions you might have about oncology medications. As part of your participation in the Ongoing Support Services, Eli Lilly and Company and Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "Lilly") may use, disclose, and/or transfer the personal information you supply to provide services related to your condition and treatment to administer the program.

**Services include:**

Contacting you by email, mail or telephone to provide personalized services, delivered by your Lilly Oncology Support Center team, such as information and marketing materials; responding to customer service requests and/or questions about your treatment; requesting feedback on your experience with the related products, services, and programs, including market research and medical research; disclosing your enrollment and use of these services to your doctors and insurers; analyzing and/or measuring program performance and program effectiveness for future enhancements; and other activities related to your condition and therapy that are not part of the Lilly Oncology Support Center. These activities include opportunities to share your story and participate in studies about products and services. To cancel your participation in the program, please contact us at **1-866-472-8663** Mon-Fri, 8am–10pm EST.

**Privacy Notice:**

We may use and save your personal information to meet legal or regulatory obligations that are in the legitimate interest of Lilly, to fulfill legitimate and lawful business purposes in accordance with Lilly's record retention policies and applicable laws and regulations, and to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests.

Your information may be combined with other information that you have previously provided or that Lilly has received. We do not sell personal information.

We may transmit personal information about you to other Lilly affiliates worldwide. These affiliates may in turn transmit personal information about you to other Lilly affiliates. Some of Lilly's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Lilly's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about Lilly's privacy practices, including the basis for transfers and safeguards that Lilly has in place for cross-border transfers of personal information, please contact us at privacy@lilly.com or visit https://www.lilly.com/privacy.

We provide reasonable physical, electronic and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Lilly. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches.

Upon verification, you have the right to request information from us regarding how your personal information is being used and with whom that information is being shared. You also have the right to request to see and get a copy of the personal information that we have about you, request its correction or request its erasure/deletion.

There may be exceptions that apply to your request.

In limited circumstances, you may have the right to have your information transmitted to another entity or person in a machine-readable format.

You will not be discriminated against for exercising any of your rights.

To exercise your rights, you or your authorized representative may submit a request by contacting us using one of the methods listed below.

You may make any of the above requests by contacting us at: The Lilly Answers Center, Lilly USA, LLC, Lilly Corporate Center, Indianapolis, IN 46285 or by calling 1-800-545-5979.

If you wish to raise a complaint on how we have handled your personal information, you can contact the Global Privacy Office and Data Protection Officer at privacy@lilly.com who will investigate the matter.

If you are not satisfied with our response or have any concerns about how your data is being processed, you can register a complaint with a relevant regulatory authority (e.g. a Data Protection Authority (DPA) or Attorney General).