

PatientOne

1-866-4PatOne | www.LillyPatientOne.com

6900 College Boulevard, Suite 1000 Overland Park, KS 66211 phone: 1-866-472-8663 fax: 1-888-242-6230

Check the box below that applies, complete and fax to 1-888-242-6230:

[] Patient Assistance Program (Uninsured Patients)

[] Patient Assistance Program (Insured Patients)

NOTE: The required number of appeals must be completed prior to this request and documentation must have been received on the denial of those appeals.

PATIENT INFORMATION: (Please print or type)

PATIENT NAME (FIRST, MI, LAST): GENDER: M F
SSN: DOB:
ADDRESS:
CITY: STATE: ZIP:
MONTHLY OUT OF POCKET MEDICAL EXPENSES: # IN HOUSEHOLD

MONTHLY GROSS HOUSEHOLD INCOME: **
Include salary, pension, social security, disability, alimony, child support, interest/dividends, rental property, etc.

**Proof of Income Required: Copy of W-2; copy of prior year tax return; copy of most recent pay stub; copy of social security check or awards letter

PHYSICIAN/SHIPPING INFORMATION: (Please print or type)

PHYSICIAN NAME: FACILITY NAME
PHYSICIAN NPI # FACILITY NPI #
SHIPPING ADDRESS:
CITY: STATE: ZIP:
CONTACT NAME: PHONE # / EXT #: FAX #:

DRUG ADMINISTERED:

START DATE:

INSURANCE INFORMATION:

** Please provide copies of all insurance cards (front/ back) **

Does the patient have Medicare Coverage: [] YES [] NO

If Medicare, check all that apply: [] Part A [] Part B [] Part D

Medicare Policy #: Effective Date:

If Patient has Part D, list Prescription Drug Plan information below

Insurance Name:

Telephone:

Policy ID Number:

Private Primary Insurance: [] YES [] NO

Insurance Name:

Telephone:

Policy ID Number:

Secondary Insurance [] YES [] NO

Insurance Name:

Telephone:

Policy ID Number:

Veterans /Medicaid/Other Insurance: [] YES [] NO

Insurance Name:

Telephone:

Policy ID Number:

PLEASE PROVIDE A COPY OF INSURANCE CARDS (Front and Back)

By signing below, I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I also represent that I have received an appropriate HIPAA authorization, and other authorizations, from the patient to disclose this information, as well as other medical information that may be disclosed, including medical records of the patient, to Eli Lilly and Company and Lilly USA, LLC and its agents for the purpose of assessing whether the patient qualifies for any reimbursement benefits through the duration of the patient's therapy.

I certify I am currently licensed to prescribe and receive drug and that the information provided by me herein is accurate and complete. I understand that the patient must meet financial parameters to be eligible under the program. I attest to the patient's financial need. I certify that I have not received reimbursement for the drug requested or previously administered. I certify that no free vials provided under this program will be distributed for sale to any individual or organization. I understand that if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Lilly USA, LLC will bill for the covered product, and I agree to be responsible for payment of the bill. I understand that if the patient's income or insurance status changes, the patient may no longer be eligible under this program. I agree to immediately notify a program representative if the patient's insurance or income status changes. I understand that the program may be changed or terminated without prior notice. I understand that I am under no obligation to prescribe any Lilly drug to participate in this program and that I have not received nor will I receive any benefit from Lilly USA, LLC or AccessMED, Inc. for prescribing a Lilly drug. I understand that AccessMED, Inc. and Lilly USA, LLC are not responsible for filing any insurance claim. I certify that the payer's required number/level of appeals have been completed for this request and I have received denials on each of those appeals. Additionally, I understand this information will be subject to potential random reviews. I agree to abide by this certification throughout my participation in the program and to notify a program representative if aspects of my certification are no longer applicable. I attest that the information contained in this form is complete and accurate to the best of my knowledge.

Original Signature of PHYSICIAN Date