

6900 College Boulevard, Suite 1000 Overland Park, KS 66211 phone 1-866-472-8663 fax 1-877-366-0585 email Lilly.PatOne@AccessMED.com

Check the box below that applies, complete and fax to 1-877-366-0585:

[] Patient Assistance Program (Uninsured Patients)

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 INFORMATION: (Please print or type)

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

DRUG REQUESTED :

[] Denied Claim Appeals Program (Insured Patients)

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 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)

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 from the Patient to disclose this information 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.

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 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 _____