PatientOne

PatientOne Enrollment Form

OFFICE STAFF:
- Please return all pages (including p. 2), via Fax, to **1-877-366-0585**
- For questions or concerns, please call PatientOne at **1-866-4PatOne** (1-866-472-8663)

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

All fields required, unless noted.

1. Patient Information

Name (First, Middle, Last)_____ Sex: M ☐ F ☐ DOB (MM/DD/YYYY)_____

Address_____ City _____

State_____ ZIP Code_____ Email _____ Primary Phone Number* _____

***By providing my mobile telephone number and signing this form, I agree to receive automated calls and texts about PatientOne, and I understand that no purchase is necessary to receive these calls or texts.**

I have read and agree to the Patient HIPAA Authorization on p. 2 of this form. ☐ I consent to my enrollment in the Additional Services outlined on p. 2 of this form (optional).

X_____ **Date (MM/DD/YYYY)** _____

Signature of Patient

2. Insurance Information Please Do Not Submit any additional Documentation, other than Insurance Card(s)

☐ **No insurance coverage** Patients who have no insurance or whose insurance does not cover the Lilly oncology medication may apply to LillyCares by completing a separate application found at www.LillyCares.com or may call 1-800-545-6962.

☐ Copy of the policyholder's insurance card (front and back) is attached **OR** ☐ Complete the following insurance information:

Primary Insurance Company _____ Policyholder _____ Insurance Company Phone _____

Primary # _____ Group # _____

Secondary Insurance Company _____ Policyholder _____ Insurance Company Phone _____

Secondary # _____ Group # _____

3. Support Requested for This Patient

Select the options below that your patient or your office would like to receive:

☐ **Reimbursement Assistance**
Benefit Investigation, Prior Authorization, Appeals Research

ALIMTA® (pemetrexed for injection)
CYRAMZA® (ramucirumab)
ERBITUX® (cetuximab)
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

Please be sure to have your patient read and sign page 3 if applying for the Co-Pay Program

4. Prescriber Information

Name (First, Last) _____ NPI # _____ [Practice Name] _____

Address _____

City _____ State_____ ZIP Code _____ Phone _____ Fax _____

Office Contact Name _____ Office Contact Phone _____

Physician Medicaid ID _____ Physician Tax ID # _____

5. Clinical Information Please Do Not Submit any additional Documentation

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:

☐ ALIMTA
☐ CYRAMZA
☐ Portrazza
Start Date _____

☐ ERBITUX
☐ LARTRUVO
Please select only one product per form

Diagnosis (ICD-10) Code_____

RAS Tested? (ERBITUX only) ☐ Yes ☐ No Results_____

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

Prescriber Signature

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; and 5) I am licensed to prescribe the prescription medication identified in this form; 6) Treatment for patients enrolled in the Lilly PatientOne Co-pay Program is for an FDA-approved indication; 7) to the best of my knowledge the patient meets the insurance and residency requirements (for those applying for the Lilly PatientOne Co-pay Program).

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN
Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

X_____ **Date (MM/DD/YYYY)** _____

Lilly

 For questions or concerns, please call PatientOne at **1-866-4PatOne** (1-866-472-8663)

What Is PatientOne and How Can It Help Me?

Your healthcare provider has talked with you about using PatientOne, an Eli Lilly and Company Patient Support Program. You may have some questions about this. PatientOne was created to help you have a good experience as you get started with and use your medicine. PatientOne offers personalized support to patients at no charge. PatientOne consists of people who work for Lilly, plus companies that Lilly has chosen to provide some services. For the rest of this form, "Lilly" and "we" or "us" will stand for Eli Lilly and Company, Lilly USA, its affiliates, agents, representatives, business partners, and service providers.

Sharing Your Protected Health Information

Before PatientOne 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*.

PHI includes information like:

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

If you agree, your PHI may be shared by:

- Your doctors and other healthcare providers
- Your healthcare plan or health insurance company
- 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 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 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.
- You don't have to give permission to share your PHI, but PatientOne 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 permission to share and use your PHI lasts for 1 year, unless you change your mind before then. You can stop allowing your PHI to be shared at any time, but this will not affect information or disclosures shared before Lilly receives your request.
- Your healthcare providers (such as pharmacies) may be paid by us in exchange for sharing your PHI. They may use your information to provide services, such as contacting you about Lilly products.

If you change your mind about taking part in the program:

- You can stop sharing your PHI with us or change what you share by calling us at 1-866-4PatOne (1-866-472-8663) or by writing us at PO Box 12307, La Jolla, CA 92039.
- We will follow your wishes after we hear from you.

Additional Services (Optional)

Lilly PatientOne offers additional services related to your condition and therapy. They are not part of the Lilly PatientOne basic services, which consist of reimbursement and/or co-pay support. As part of my participation in these additional services, Lilly PatientOne may use, disclose and/or transfer the personal information I supply to provide services related to my condition and treatment. Lilly PatientOne may also use my information to analyze and/or measure program performance or future enhancements. In addition, Lilly may contact me by email, mail or telephone to provide personalized service delivered by my PatientOne Representative, which may include: Providing Informational and marketing materials to me; Responding to my customer services requests and/or product questions; Requesting feedback on my experience with related products, services, and programs; Giving me opportunities to participate in market research activities; Giving me opportunities to tell my story, and providing opportunities to take part in studies about products and services.

By checking the corresponding box on the front of this form, I consent to my enrollment in the Additional Services program outlined above.

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.

X_____**Date (MM/DD/YYYY)** _____

Print Patient Name

X_____**Date (MM/DD/YYYY)** _____

Signature of Patient

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