

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

Address: PO Box 4280
Gaithersburg, MD 20885-4280

Phone: 1-866-472-8663 Option 2
Fax: 1-877-366-0585

Important Information on Available Support

- Reimbursement Support is for ALIMTA[®] (pemetrexed for injection), CYRAMZA[®] (ramucirumab), ERBITUX[®] (cetuximab), and Portrazza[™] (necitumumab) only.
- The Lilly PatientOne Co-pay Program is available only for ALIMTA, CYRAMZA, ERBITUX, and Portrazza when administered for an FDA-approved indication.

3-Step Registration

Step 1 - Complete the Application

- Check the box in section **1** for all support requested (note that we will reach back to you if we find that your patient may need or qualifies for other support offered by the program).
- Be sure to complete the physician and patient information sections.
- If you are applying for the Patient Assistance Program or Lilly PatientOne Co-pay Program, please be sure to complete that section of the application and **include the appropriate financial documentation**.

Step 2 - Read and Sign

- Please ensure the physician and patient read and sign appropriately for the services being requested.
- Certification for Lilly PatientOne Co-pay Program for ALIMTA, CYRAMZA, ERBITUX, or Portrazza (page 5) if applying for the co-pay card.
- Please remember to include a copy of the insurance cards where applicable.
- Stamped signatures or signatures by persons other than the prescribing healthcare physician are not acceptable.

Step 3 - Fax the Application

- **Fax the completed application and any supporting documents to 1-877-366-0585. We recommend that you return the completed form via fax in order to expedite the process.** Once the application is received, we will notify the physician's designated office contact (in section **2**) of the results.

Incomplete or incorrect information may delay the process, so please ensure all information is provided correctly and signatures are obtained.

Should you have any questions, please call 1-866-4PatOne (1-866-472-8663).

A PatientOne Specialist will be in touch with you very soon with the results.

Confidentiality Notice: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

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PatientOne Assistance Application

IMPORTANT: A completed Patient Authorization (attached) must be signed and submitted before patient-specific research can begin.

1 SUPPORT REQUESTED Please check appropriate boxes.

- Reimbursement Assistance Benefit Investigation, Prior Authorization, Claims Assistance
ALIMTA (pemetrexed)
CYRAMZA (ramucirumab)
ERBITUX (cetuximab)
Portrazza (necitumumab)

FDA-approved and Compendia use only

- Patient Assistance Program Product Replacement for Qualified Patients
ALIMTA (pemetrexed)
CYRAMZA (ramucirumab)
ERBITUX (cetuximab)
GEMZAR (gemcitabine)
Portrazza (necitumumab)

FDA-approved and Compendia use only

- Lilly PatientOne Co-pay Program For Qualified Commercially Insured Patients
ALIMTA (pemetrexed)
CYRAMZA (ramucirumab)
ERBITUX (cetuximab)
Portrazza (necitumumab)

FDA-approved use only

2 PHYSICIAN INFORMATION

Facility Name Facility NPI
Physician's Name Physician's NPI
Physician's Specialty Physician's State License
Physician's Tax ID
Physician's PTAN Physician's Medicaid ID
Address
City State ZIP
Office Contact/Requester's Name
Contact Phone Number/Extension Contact Fax Number

3 PATIENT INFORMATION

Patient's Name (First, MI, Last) Gender M/F
Address
City
State ZIP
Phone Number Cell Phone (Optional)
SSN
DOB

4 TREATMENT INFORMATION

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: Start Date
ALIMTA ERBITUX
CYRAMZA GEMZAR (for PAP only)
Portrazza
Diagnosis (ICD-10) Code
RAS Tested? Yes No Results if tested

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5 INSURANCE INFORMATION Please include Medicare, Medicaid, and/or other government plans. Please provide copies of all insurance cards (front/back).

Primary Insurance:

Insurance Name _____ Telephone _____

Subscriber Name _____ Policy ID # _____ Group ID # _____

Secondary Insurance:

Insurance Name _____ Telephone _____

Subscriber Name _____ Policy ID # _____ Group ID # _____

6a COMPLETE THIS SECTION FOR PATIENT ASSISTANCE PROGRAM AND CO-PAY PROGRAM

Monthly Gross Household Income _____ # in Household _____

* Include salary, pension, Social Security, disability, alimony, child support, interest/dividends, rental property, etc.

** Must be a permanent, legal US resident.

*** Please submit proof of income with this application. Examples of acceptable documents include, but are not limited to: yearly benefits statement (SSA, 1099, or awards letter); copy of prior year tax return; copy of most recent pay stub.

6b ALSO COMPLETE THIS SECTION FOR THE LILLY PATIENTONE CO-PAY PROGRAM

Will CYRAMZA, ERBITUX, or Portrazza be ordered directly from a specialty pharmacy?

Yes No

Physician Acknowledgment

By signing the below, I certify:

- The information provided is accurate to the best of my knowledge
- The therapy is medically necessary. I also represent that I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient, to Eli Lilly and Company, the Lilly Cares Foundation, Lilly USA, LLC and their vendors, business partners, and agents for the purpose of assessing whether the patient qualifies for any reimbursement or Patient Assistance Program benefits through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Lilly so that Lilly may contact the patient to further enable these services
- I am licensed, will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above Patient, and prescribed the medication to this patient based on my independent clinical judgment that treatment with this medicine for this patient is medically necessary

Patient Assistance Program/Co-pay Program

- Treatment for patients enrolled in the *Patient Assistance Program* is for FDA-approved indication and/or Compendia use
- Treatment for patients enrolled in the *Lilly PatientOne Co-pay Program* is for an FDA-approved indication
- To the best of my knowledge the patient meets the financial, insurance, and residency requirements of each program respectively. For the Patient Assistance Program, patients must be permanent, legal US residents. If I am aware the patient no longer meets the criteria for the programs I agree to immediately notify a program representative
- I have not received and will not seek reimbursement or payment for all or any part of the benefit received by the patient through the programs
- Any medication provided by Lilly USA, LLC, or the Lilly Cares Foundation for this patient through the Patient Assistance Program will not be resold, nor offered for sale, trade or barter, or returned for credit
- The payer's required number/level of appeals have been completed for a Patient Assistance Program request and I have received denials on each of those appeals

I understand:

- Lilly USA, LLC, or the Lilly Cares Foundation as appropriate, may change, terminate, suspend participation, limit enrollment, or recall/discontinue medications in the program without prior notice
- I am under no obligation to purchase or 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, the Lilly Cares Foundation or their vendors, business partners or agents for prescribing a Lilly drug
- Lilly USA, LLC, the Lilly Cares Foundation, and their vendors, business partners, and agents are not responsible for filing any insurance claim
- The information provided will be subject to potential random reviews
- If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Lilly USA, LLC, or after January 1, 2016, the Lilly Cares Foundation, will bill for the covered product, and I agree to be responsible for payment of the bill

Original Signature of PHYSICIAN _____ **Date** _____

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Patient Protected Health Information Disclosure and Attestation

- PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE. YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.
- The Patient Assistance Program, Reimbursement Program, and PatientOne Co-pay card featuring ALIMTA, CYRAMZA, ERBITUX, or Portrazza Program ("PatientOne Support Programs") are available free of charge from Lilly USA, LLC ("Lilly"). As of January 1, 2016, product provided free of charge to eligible patients currently through the Lilly PatientOne Patient Assistance Program will be provided by the Lilly Cares Foundation, an independent non-profit 501(c)(3) organization that helps eligible patients obtain certain products listed in this application free of charge and PatientOne will collect information on behalf of the Lilly Cares Foundation for that purpose. If you don't have a healthcare plan, or your healthcare plan won't pay for your prescribed Lilly treatment and you meet certain financial and medical standards, we will work with you and your physician(s) to find possible sources of reimbursement.
- I understand that I am submitting this application or my doctor's office is submitting it on my behalf, to see if I qualify for financial assistance with my Lilly medications as part of a patient assistance program and other services offered by Lilly or the Lilly Cares Foundation to help me find possible sources of financial assistance, or to assess whether I have insurance coverage for the Lilly medication (the "Patient Assistance Programs"). I understand that before you can assist me, you may need to collect, use, and disclose information about me that is requested on this application, including my Protected Health Information ("PHI"), my financial information (for example, my Social Security Number) and other personal information about me (collectively "My Personal Information"). PHI that will be disclosed includes any information related to my healthcare insurance or plan benefits, including coverage limits and other information related to my health and treatment, including possible sensitive material relating to sexually transmitted diseases, mental health conditions, and/or genetic testing; as well as any information that has a bearing on my health or whether I'm staying on my medicine or treatment. Although you are not looking for Protected Health Information that is unrelated to my Lilly treatment, it may be part of the health records sent to you.
- I understand that by signing this form, I am permitting my doctor's office, my healthcare plan or insurance company, my pharmacies, as well as other entities that may hold my PHI, to release My Personal Information, including my PHI, to Lilly, the Lilly Cares Foundation, and to their vendors, business partners and agents who may be assisting with the administration of the PatientOne support programs ("Lilly's Representatives"). I understand that to provide the services for the PatientOne support programs, Lilly, the Lilly Cares Foundation, and the Lilly Representatives may need to further disclose My Personal Information to and communicate with other Lilly Representatives involved with PatientOne support programs, my doctor's office or other healthcare providers, including my insurance company or health plan or pharmacies.
- I attest that I am a permanent, legal US resident.
- I further understand that Lilly, the Lilly Cares Foundation, and the Lilly Representatives will use My Personal Information in the following manner:
 - (1) to review my application for any of the PatientOne and/or the Lilly Cares Foundation support programs, and to help determine my healthcare plan coverage for Lilly medications prescribed by my doctor and other procedures as part of my therapy on Lilly medications;
 - (2) to contact me or my doctor's office or other of my healthcare providers, as necessary, to conduct such services; and (3) for purposes relating to the operation and administration of the PatientOne and/or the Lilly Cares Foundation support programs, including measuring and tracking the quality of the services, and the consideration of assistance possible in other Lilly Patient support programs, or to make me aware of alternative sources of funding and programs, including third-party nonprofit organizations and programs; (4) track my use of prescribed Lilly treatments. I also understand that Lilly, the Lilly Cares Foundation, and the Lilly Representatives can contact me to collect any additional information needed to provide these services to me.
- **I understand that I do not have to sign this consent**, but if I do not, I will not receive the described services. I understand that I might need to pay for my Lilly medication on my own, whether I sign this form or not. I understand that once my doctors, healthcare plan, pharmacies, or others who have my Protected Health Information release it, my information may no longer be covered by Federal and State Privacy Law (for example, HIPAA).

This authorization allows those who rely on it to release my Protected Health Information for 1 year from the date I have signed it. I understand that I can withdraw it at any time by sending a written notice to the address listed above. My withdrawal goes into effect once it is received by the program. I also understand that by withdrawing, I may not receive or I may stop receiving the services provided under this program.

PATIENT or Legal Guardian Signature

 _____ Date _____

Printed Name of Patient or Legal Guardian _____

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Additional Services Patient Authorization

In addition to the services I have authorized above, I understand that Lilly also offers certain free patient services and Lilly product programs related to my therapy. I would like to take part in these programs and understand that these services are optional and my decision to participate or not in these additional programs will not impact the services I have authorized above. In order for me to receive these additional patient program services from Lilly, Lilly needs this separate consent to receive and use my Protected Health Information for these programs. I understand that these services may include communicating with me by mail, email, and phone and that such communications may include marketing materials and offers for product training and support, or other services that may become available, or requests from Lilly for my participation in market research. I also understand that Lilly may share information from my participation in these programs with my healthcare provider. To withdraw my consent, I understand that I must contact the program in writing at the address above. My withdrawal goes into effect once it is received by the program. By signing below, I consent to these services and certify that I am at least eighteen (18) years of age.

PATIENT or AUTHORIZED REPRESENTATIVE Signature



Date _____

Lilly PatientOne Co-pay Program Terms and Conditions

Eligibility:

(1) You have commercial insurance that covers ALIMTA® (pemetrexed for injection), CYRAMZA® (ramucirumab), ERBITUX® (cetuximab) injection, or Portrazza™ (necitumamab), but your insurance does not cover the full cost; that is, you have a co-pay or coinsurance obligation. (2) 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. (3) You are 18 years of age or older and are receiving ALIMTA, CYRAMZA, ERBITUX, or Portrazza for an FDA-approved use. Please see a list of approved uses in the full US Prescribing Information, available from your doctor. (4) You are a resident of the United States or Puerto Rico. (5) Your adjusted gross household income is not more than the greater of \$100,000 or 500% of the Federal Poverty Level (FPL). You must provide documented proof of your income, such as a copy of your most recent Federal Tax Return or Social Security Statement.

Program Benefits:

(6) The patient must first pay a portion of their co-pay or coinsurance (\$25 for each dose of ALIMTA, ERBITUX, or Portrazza and \$50 for each dose of CYRAMZA). The program will cover the remainder of the patient's co-pay or coinsurance for ALIMTA, CYRAMZA, ERBITUX and Portrazza, up to a maximum of \$42,000 during a 12-month enrollment period. (7) In order to receive program benefits, the patient or provider must submit an Explanation of Payment (EOP) form. The submitted form must include the name of the insurer and the plan, and show that ALIMTA, CYRAMZA, ERBITUX or Portrazza was the medication that was given. A claim for reimbursement must be submitted within 180 days of infusion to receive program benefits. (8) The program may provide assistance for co-pays or coinsurance for doses of ALIMTA, CYRAMZA, ERBITUX, or Portrazza that the patient received within 60 days prior to the date of enrollment, but not prior to the date an application was submitted. The program will not provide support for doses of ALIMTA, CYRAMZA, ERBITUX, or Portrazza that the patient received before the application was submitted. (9) Program benefits are limited to the co-pay or coinsurance costs for doses of ALIMTA, CYRAMZA, ERBITUX, or Portrazza 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.

Program Timing:

(10) The enrollment period is 12 months from the date of enrollment. (11) Patients must enroll by December 31, 2016, to be eligible to receive benefits. (12) Absent a change in Massachusetts law, effective July 1, 2017, Massachusetts residents will no longer be able to participate in this program.

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Additional Terms and Conditions of Program:

(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 ALIMTA, CYRAMZA, ERBITUX, or Portrazza. (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.

Signature of PATIENT or AUTHORIZED REPRESENTATIVE

 _____ **Date** _____

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