Lilly Oncology Support Center

PATIENT ENROLLMENT SECTION
Infused Products

PUBLISHED 03/2024

OFFICE: Complete the entire form and submit pages 1-4 to the Lilly Oncology Support Center™ via fax at 1-877-366-0585
For assistance, call 1-866-472-8663,
Monday-Friday 8am – 10pm ET.

Section 1: Patient Information

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

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

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

Phone* _____ **Email** _____

☐ *By checking the box, 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 receiving goods and services. Message and data rates may apply.

☐ By checking the box, I agree to be contacted to: provide feedback on my experience with the related products, services, and programs; to share my story; and, to participate in market and medical research studies about products and services.

Section 2: Insurance Information

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** _____

Secondary Insurance Company _____

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

Policy/ID _____ **Group #** _____

☐ No ☐ Yes **The primary insurance listed above is a commercial coverage plan and is active.**

☐ No ☐ Yes **Do you use government insurance to fill your prescriptions? Examples include Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS**

Section 3: Service Selection

Please select which options you would like to enroll in by checking the corresponding checkboxes below. By enrolling in any of these services below, you are agreeing to the Terms of Participation and consenting to the collection of your information, inclusive of health information as described under the Privacy Notice on page 5.

☐ **1. Lilly Oncology Infused Products™ Savings Card**

SAVINGS CARD ELIGIBILITY (must confirm the below statements in order to be eligible)

☐ I confirm that I am a resident of the United States or Puerto Rico who is 18 years of age or older

☐ I confirm that I am NOT enrolled in a government-funded prescription program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state patient or pharmaceutical assistance program

☐ **2. Lilly Oncology Support Center™ Ongoing Support**

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using Eli Lilly and Company medicine. The Lilly Oncology Support Center™ offers personalized support to Patients at no charge and was created to help you have a positive experience as you get started with and use this medicine. By checking the corresponding optional boxes above, you consent to your enrollment into the Lilly Oncology Support Center™. As part of your participation in the Lilly Oncology Support Center™, you understand and authorize Lilly USA, LLC to retain and use your personal information for the purposes described in this form. Eli Lilly and Company, 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. The Lilly Oncology Support Center™ Support team can contact you by email, mail or telephone to provide personalized services and information and materials directly related to your condition and therapy; responding to customer service requests and/or questions about your treatment; disclosing your enrollments 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 part of the Lilly Oncology Support Center™. Your personal information, including information that may be related to your health, is needed to fulfill your request. To cancel your participation in the program, please contact us at 1-866-472-8663 Mon-Fri, 8am -10pm ET. For information about Lilly's privacy practices, please see our Privacy Statement at https://privacynotice.lilly.com.

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 Signed (MM/DD/YYYY)** _____

Printed Name of Patient _____ **Date of Birth (MM/DD/YYYY)** _____

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

Please continue to the next page.

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By enrolling in the Lilly Oncology Infused Products Savings Card Program ("Program") and using the Lilly Oncology Infused Products Savings Card ("Card"), 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 Savings Card Program and have a prescription consistent with FDA-approved product labeling: Cyramza® (ramucirumab) or Erbitux® (cetuximab)
(2.) You are enrolled in a commercial insurance plan
(3.) **You are not participating in any state, federal, or government funded healthcare program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state prescription drug assistance program.**
(4.) You are a resident of the United States or Puerto Rico
(5.) You are 18 years of age or older

You must have coverage for your prescribed Lilly Oncology medicine through your commercial insurance, but your insurance does not cover the full cost, to pay as little as $25 for each infusion of your prescribed Lilly Oncology medicine and be enrolled in the Program. Card savings are subject to a maximum monthly savings of wholesale acquisition cost plus usual and customary fees and separate maximum annual savings of $25,000 per calendar year. After the monthly and/or annual maximum savings are reached, you will be responsible for paying any remaining monthly/annual out-of-pocket costs. For enrolled patients, the Program may provide support for infusions with a date of service that falls within 120 days prior to the date the enrollment form is received by the Program. To receive Program savings, your healthcare provider must submit a claim for coverage to your medical insurance provider. If your medical insurance provider does not cover the full cost of the claim, your healthcare provider must then submit an Explanation of Benefits (EOB) form and a CMS 1450 or 1500 form including the name of the insurer and plan demonstrating your prescribed Lilly Oncology medicine (Cyramza or Erbitux) was the medication administered to the Lilly Oncology Support Cener within 180 days of the infusion date of your prescribed Lilly Oncology medicine. You understand and agree Lilly will make a payment of your Program on your behalf to your healthcare provider. Subject to Lilly USA, LLC's (Lilly") right to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions which may occur at Lilly's sole discretion, without notice, and for any reason, Card expires and savings end on 12/31/2024.

Additional Terms and Conditions

If you have an insurance plan that is participating in an alternate funding program ("AFP") (examples include, but are not limited to, ImpaxRX, Payer Matrix, SHARx, Script Sourcing, and Paydhealth) that requires you to apply to the Lilly Oncology Infused Products Savings Card Program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of your prescribed Lilly Oncology medicine, you are not eligible for and are prohibited from using the Lilly Oncology Infused Products Savings Card Program. AFPs include programs where coverage, reimbursement, or patient out of pocket costs for a product in some way vary based on the availability of a manufacturer co-pay program. AFPs may modify, delay, deny, restrict, or withhold insurance benefits or coverage from patients, or exclude Lilly Products from coverage contingent upon a member's use of the Lilly Oncology Infused Products Savings Card Program. You agree to inform the Lilly Oncology Infused Products Savings Card Program if you are or become a member of such an alternate funding program. You are responsible for any applicable taxes, fees, and any amount that exceeds the monthly or annual maximum savings. Monthly and annual maximums are set at Lilly's sole and absolute discretion and may be changed with or without notice at any time for any reason. At its sole discretion and with or without notice, Lilly may reduce, eliminate, or otherwise modify the Card savings for any reason, including but not limited to if your commercial insurance plan imposes additional requirements which limits or prevents you from receiving coverage for your prescribed Lilly Oncology medicine, only allows partial coverage for your prescribed Lilly Oncology medicine, removes coverage for your prescribed Lilly Oncology medicine and requires you to utilize the Card, does not provide a material level of financial assistance for the cost of your prescribed Lilly Oncology medicine, or does not apply Card payments to satisfy your co-payment, deductible, or coinsurance for your prescribed Lily Oncology medicine.

Program savings are limited to the co-pay or coinsurance costs for your prescribed Lilly Oncology medicine only, subject to a monthly and annual maximum savings, outlined above. 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. Participation in the Program requires a valid patient HIPAA authorization to enroll in the Program. Card savings are not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. You must meet the Card eligibility criteria, terms and conditions every time you use the Card. If at any time you begin receiving coverage under any state, federal, or government funded healthcare program, you understand that you will no longer be eligible for the Lilly Oncology Infused Products Savings Card Program and agree to call the Lilly Oncology Support Center at 1-866-472-8663 to stop participation. No party may seek reimbursement from your health insurance, any third party, or any health savings, flexible spending, or other healthcare reimbursement accounts, for any amount of the savings received through the Card. By utilizing the Card, you agree that if you are required to do so under the terms of your insurance coverage for this prescription or are otherwise required to do so by law, you will notify your Insurance Carrier of your redemption of the Card. Card savings cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, incentive, or similar offer involving your prescribed Lilly Oncology medicine. You agree that this Card savings is intended solely for the benefit of you, the patient, and that the Card benefits are nontransferable. It is prohibited for any person to sell, purchase, or trade; or to offer to sell, purchase, or trade, or to counterfeit the Card. The Card is not insurance. Lilly has the sole right to interpret and apply Card eligibility criteria, and terms and conditions. Card eligibility, and terms and conditions may be terminated, rescinded, revoked, or amended by Lilly at any time without notice and for any reason. Eligibility criteria, and terms and conditions for the Lilly Oncology Infused Product Savings Card Program may change from time to time; the most current version can be found at https://www.lillyoncologysupport.com. You may be required to obtain a new Card, including if any Card terms and conditions have been terminated, rescinded, revoked, or amended by Lilly. Card void where prohibited by law. Subject to Lilly USA, LLC's right to terminate, rescind, revoke or amend Card eligibility criteria and/or Card terms and conditions which may occur at Lilly's sole discretion, without notice, and for any reason, the Card expires and savings end on 12/31/2024.

Please continue to the next page.

Lilly Oncology Support Center

PATIENT HIPAA AUTHORIZATION

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Before the Lilly Oncology Support Center™ can start helping you, Lilly may ask for some information about you and your health from your Health Care Entities (as defined below). 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

If you agree, your PHI may be shared by these entities (together "Health Care Entities"):

- 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 on behalf of your healthcare providers, pharmacies and healthcare plans

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 with others by Lilly
- 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 501847, Rancho Bernardo, CA 92150, 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
- **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 501847, Rancho Bernardo, CA 92150**
- **Your cancellation or revocation of this Authorization will be effective when your Health Care Entities receive notice of your cancellation or revocation, and will not apply to any information shared with Lilly by your Health Care Entities prior to the time those Health Care Entities receive notice**

By signing this form, I attest that I have read and agree to the Patient HIPAA Authorization. I understand I am entitled to a copy of this signed Authorization.

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

Printed Name of Patient _____ **DOB (MM/DD/YYYY)** _____

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PRESCRIBER ENROLLMENT SECTION
Infused Products

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Section 4: Prescriber information

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

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

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

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

Office Contact Email _____ **Secondary Office Contact** _____

Section 5: Diagnosis

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

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

Diagnosis:

ICD-10 Code _____

Section 6: HCP Service Selection & Prescription

☐ **Benefits Investigation - (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 BELOW.**

☐ **Savings Card Program Support (FDA Approved Use Only)** – For Qualified, Commercially Insured Patients Only – **IF CHECKED, PATIENT MUST REQUEST A SAVINGS CARD AND PROVIDE THEIR SIGNATURE ACCEPTING THE SAVINGS CARD TERMS AND CONDITIONS FROM PAGE 1.**

Specialty Pharmacy or Institution where prescription was sent _____

Specialty Pharmacy/Institution Phone Number _____

Valid enrollment includes: Treatment Setting, 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 select the Product Prescribed

Product Prescribed: PLEASE SELECT ONLY ONE PRODUCT PER FORM

☐ **CYRAMZA®** ☐ **ERBITUX®**

If diagnosis is metastatic colorectal does your Patient have KRAS wild-type disease (no mutation)? ☐ **YES** ☐ **NO** ☐ **Unknown**

Start Date _____

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 or an indication medically supported by CMS recognized Compendia; 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 Signed (MM/DD/YYYY)**

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Privacy Notice:

This Privacy Notice ("Notice") is intended to supplement the Eli Lilly and Company Privacy Statement (https://privacynotice.lilly.com) and the Consumer Health Privacy Notice (https://www.lillyhub.com/legal/lillyusa/CHPN.html) that can be accessed in the footers of Lilly's websites. This Notice is to provide you with information about the personal information, including health information, we may collect, use, disclose or otherwise process, and your rights and choices with respect to your information.

The categories of health information we collect will depend on how you interact with Lilly Services and the information you choose to provide. We may collect:

- Health conditions, treatments, diseases, or diagnosis
- Social, psychological, behavioral, and medical interventions
- Health-related surgeries or procedures
- Use or purchase of prescribed medication
- Bodily functions, vital signs, symptoms, or measurements of other types of consumer health data
- Diagnoses or diagnostic testing, treatment, or medication
- Reproductive or sexual health information
- Biometric data
- Genetic data
- Data that identifies a consumer seeking health care services
- Other information that may be used to infer or derive data related to the above or other health information.

With your consent, we may use the health information we collect for the following purposes, as further described in our privacy statements:

- Providing Services and support.
- Analytics and improvement.
- Customization and personalization.
- Marketing and advertising.
- Security and protection of rights.
- Legal proceedings and obligations.
- General business and operational support.

Lilly does not sell or share your health information with third parties without your consent or authorization. We may disclose health information to our processors for our business purposes or at your direction to provide you with products and Services that you request.

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.

Some of this personal information may be considered sensitive under applicable laws, such as information about your health or medical diagnosis and demographic information collected in some circumstances, such as race, ethnic origin, and sexual orientation. We may process your sensitive PI with your consent, or as otherwise permitted by law.

Upon verification, you have rights with respect to the collection, use and storage of your information. These rights may include access to your information and how it is being used or shared, the right to correct, delete or limit use of your information or to withdraw consent for us to collect and use your information. There may be certain exceptions and limitations that apply to your request including the right to have your information transmitted to another entity or person in a machine-readable format. To exercise your rights, you or your authorized representative may submit a request to datarights@lilly.com or 1-800-Lilly-Rx (1-800-545-5979). You will not be discriminated against for exercising any of your rights. You may be entitled, in accordance with applicable law, to appeal a refusal to take action on your request. To do so, please contact us by using one of the methods listed here or in How to Contact Us section of the online Privacy Statement.

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).