

6900 College Boulevard, Suite 1000 phone 1-866-472-8663
Overland Park, KS 66211 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)

[] Denied Claim Appeals Program (Insured Patients)

PATIENT INFORMATION: (Please print or type)

PATIENT NAME (FIRST, MI, LAST): M F GENDER:
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: DEA#/STATE LICENSE #:
FACILITY NAME:
ADDRESS:
CITY: STATE: ZIP:
CONTACT NAME: PHONE # / EXT #: FAX #:

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/State Program/Other Insurance: [] YES [] NO

Insurance Name:

Telephone:

Policy ID Number:

On behalf of my patient, I request assistance for the Lilly oncology drug specified in this application. I certify that I have obtained from my patient all required authorization for the release to Eli Lilly and Company and its representatives and agents of: 1) my patient's identification and insurance information, and 2) any additional medical or patient information needed for purposes of securing assistance under these programs. I understand that this information is for the sole use of Eli Lilly and Company, its representatives, and or agents to assess the patient's eligibility for participation in a Program and to appeal denied claims on the patient's behalf. I certify I am currently licensed to prescribe and receive oncology products 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, Eli Lilly and Company 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 Eli Lilly and Company or AccessMED, Inc. for prescribing a Lilly drug. I understand that AccessMED, Inc. and Eli Lilly and Company 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

I attest that the information supplied by me herein is complete and accurate. I authorize the release of the information contained herein. I understand it is for the sole use of Eli Lilly and Company, its representatives, and/or agents selected in order to assess my eligibility for participation in these Programs and to appeal denied claims on my behalf. I authorize Eli Lilly and Company, its representatives, and agents to request and obtain from my physician and any insurer, medical and other patient information related to my therapy with a Lilly oncology product for the purposes of seeking reimbursement for my chemotherapy. I further authorize these parties to contact me directly, if necessary, to process this request for assistance. I understand that application for assistance for the Lilly oncology drug specified in this application does not guarantee that assistance will be obtained. I understand eligibility under this program is subject to approval under the financial program guidelines, and that Eli Lilly and Company reserves the right to change or terminate this program without prior notice. I understand that assistance is temporary and that I may be asked to reapply at designated intervals. I agree to immediately inform my physicians and/or a program representative if my income or insurance status changes. 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.

Original Signature of PATIENT or Legal Guardian Date