LILLY MINNESOTA PATIENT ASSISTANCE PROGRAM APPLICATION

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This application is for Patients who would like to apply to the Lilly Minnesota Patient Assistance Program ("Program") which provides Eli Lilly and Company insulins to Patients at no cost.* Please complete this application and submit by fax or mail to be considered for the Program.

*Patients who are admitted to the Program may be charged a co-pay for their insulin by the dispensing pharmacy.

Medications Available:

• Basaglar® (insulin glargine injection) • Humalog® (insulin lispro injection) Family of Products • Humulin® (human insulin) Family of Products • Lilly's Portfolio of Non-Branded Insulins • Lyumjev™ (novel ultra-rapid insulin analog) Family of Products

You Qualify for the Program if:

☐ You are a permanent, legal resident of the state of Minnesota with a valid Minnesota identification card

☐ **You must have a family income that is equal to or less than 400 percent of the federal poverty guidelines (listed below);**

Total Number of Persons In your Household	*Annual Adjusted Gross Income Limit*
1	*$51,040*
2	*$68,960*
3	*$86,880*
4	*$104,800*
5	*$122,720*
6	*$140,640*
7	*$158,560*
8	*$176,480*

☐ You are not enrolled in medical assistance or MinnesotaCare;

☐ Your healthcare provider has prescribed a Lilly insulin listed above;

☐ You are not eligible to receive health care through a federally funded program or receive prescription drug benefits through the Department of Veterans Affairs; and

☐ You are not enrolled in prescription drug coverage through an individual or group health plan that limits the total amount of cost-sharing that an enrollee is required to pay for a 30-day supply of insulin, including co-payments, deductibles, or coinsurance to $75 or less, regardless of the type or amount of insulin needed.

☐ Note: If you are a Medicare Part D Patient, you must spend at least $1,000 on prescription drug coverage and meet the first three eligibility requirements listed above to qualify.

To apply to the Program, you must:

☐ **Complete** the Patient and/or Authorized Representative Enrollment Section on page 2 and **sign** where indicated. **YOU MUST SIGN ALL THREE SIGNATURE AREAS FOR THIS FORM TO BE VALID.**

☐ **Read** the Lilly Minnesota Patient Assistance Program Requirements on page 3 and **sign** where indicated.

☐ **Read** the Patient HIPAA Authorization on page 4 and **sign** where indicated.

☐ **Fax** or **mail** the following documents to the Lilly Minnesota Patient Assistance Program at 1-833-200-6304 or PO Box 12307, La Jolla, CA 92039. **Missing information may delay the processing of your application.**

- ☐ A completed and signed copy of this application.
- ☐ Proof of Minnesota residency (a copy of a state-issued identification card, driver's license, or tribal identification card). (A parent or legal guardian must provide proof of residency for Patients under 18 years old.)
- ☐ A copy of proof-of-income documentation (e.g., last year's Federal Income Tax return (IRS Form 1040), a wage statement (Form W-2), a Social Security Benefit Statement (Form SSA-1099)).
- ☐ If commercially insured, proof of plan benefit requiring out-of-pocket spend of more than $75 per 30-day supply of insulin.
- ☐ If insured through Medicare Part D, proof of year-to-date spending of at least $1,000 (e.g., an Explanation of Benefits (EOB) statement or summary from your pharmacy).

Send copies of supporting documentation only. Do not send original statements (documentation provided to the Lilly Minnesota Patient Assistance Program will not be returned).

A decision will be made regarding your eligibility within 10 business days of receipt of a completed application. This decision will be mailed to the address you provide below.

If your application for the Program is approved:

- You will receive a Statement of Eligibility to the address provided below.
- You will be eligible for the Program for 12 months from the date listed on the Statement of Eligibility.
- You must take the Statement of Eligibility, your identification, and a valid prescription to your preferred pharmacy.
  - o The pharmacy may need to order product for you, and you may not receive product right away.
  - o Although Eli Lilly and Company provides the medication for free, the pharmacy may decide to collect a copay that may not exceed $50 for a 90-day supply. If you have questions, please speak with your pharmacist or visit: https://mn.gov/boards/pharmacy/insulinsafetynetprogram/

PATIENT ENROLLMENT SECTION

PLEASE FAX TO:
1-833-200-6304

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Patient: Fill out only the Patient section and sign where indicated

Authorized Representative: Fill out both the Patient section and the Authorized Representative section and sign where indicated

Patient

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

Address _____ **City** _____ **State** _____ **ZIP Code** _____

Gender ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone* _____ **Email** _____

*By providing my telephone number and signing this form, 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 purchase. Message and data rates may apply.

The Authorized Representative should fill out the section below and sign on behalf of the Patient under the age of 18.

Authorized Representative

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

Relationship to Patient _____

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

Gender ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone* _____ **Email** _____

*By providing my telephone number and signing this form, 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 purchase. Message and data rates may apply.

By signing this form as the Authorized Representative, I represent that I am the Authorized Representative for the Patient under the age of 18.

Signature of Patient or Authorized Representative _____ **Date (MM/DD/YYYY)** _____

Not signing this form will result in a delay in processing your application.

Income Information

Number of persons living in your household, including you: _____ **Total household annual (yearly) adjusted gross income:** _____

You must submit proof of income with your application.

Insurance Information

Do you have insurance? **Yes** **No**

(check all that apply):

☐ **Medicaid** ☐ **Medicare Part D** ☐ **VA or Military** ☐ **MinnesotaCare** ☐ **Private/Commercial Insurance (e.g., employer sponsored plan)** ☐ **Other** _____

Medication Prescribed: (please select one of the medications below)

☐ Basaglar® (insulin glargine injection)
☐ Humalog® (insulin lispro injection) Family of Products
☐ Humulin® (human insulin) Family of Products
☐ Lilly's Portfolio of Non-Branded Insulins
☐ Lyumjev™ (novel ultra-rapid insulin analog) Family of Products

LILLY MINNESOTA PATIENT ASSISTANCE PROGRAM REQUIREMENTS

PLEASE FAX TO:
1-833-200-6304

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I understand that:

- Eli Lilly and Company will decide if I qualify for the Lilly Minnesota Patient Assistance Program ("Program"). I understand that my application might not be approved.
- The Program may be changed or terminated, or my enrollment in the Program may be terminated, at any time.
- If my enrollment in the Program is approved, the Program will send me a Statement of Eligibility.
- If I am denied enrollment in the Program, the Program will send me a Notification of Denial.
- The Program does NOT charge a fee for participation in the Program, but my pharmacy may collect a co-payment not to exceed $50 for a 90-day supply of insulin.
- If approved, my enrollment in the Program will expire after 12 months. After my enrollment expires, I will need to re-apply to the Program.
- The Lilly Minnesota Patient Assistance Program does not charge a fee to apply for participation in the Program. I am not required to use a third party who charges a fee to help with my enrollment, and if I use a third party who charges a fee to help with my enrollment or refills of my medication, this money is not paid to the Lilly Minnesota Patient Assistance Program.

I certify (agree) that:

- I am a resident of the state of Minnesota.
- I meet the qualifications to be eligible for the Program, as outlined in this application.
- My application is complete and accurate. I have been truthful about my insurance coverage and my household income.
- I have provided (or promptly will provide) the necessary documentation, outlined in this application, to assess my eligibility for the Program. I will promptly provide additional documentation, if needed and requested by the Program, to assess my eligibility. I understand that a delay in submitting necessary documentation may result in a delay in determining my eligibility, termination of my application, or termination from the Program.
- If my application is approved:
  - o I will notify the Program of changes to my income or insurance status.
  - o I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Program.
  - o If I have Medicare Part D coverage, I will inform my Part D Plan about my enrollment in the Program, and I will not seek to have the cost/value associated with the medication I receive through the Program counted as out-of-pocket costs for prescription drugs.
  - o I will not sell, trade, or transfer any medication I receive through the Program.
  - o I will comply with the rules of the Program, including those outlined in the Minnesota law.

I certify and agree to the above Lilly Minnesota Patient Assistance Program Terms and Conditions.

By signing this Authorization, I represent that I am the Authorized Representative for the Patient under the age of 18.

Signature of Patient or Authorized Representative _____ **Date (MM/DD/YYYY)** _____

Not signing this form will result in a delay in processing your application.

PATIENT HIPAA AUTHORIZATION

PLEASE FAX TO:
1-833-200-6304

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Before the Lilly Minnesota Patient Assistance Program 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.* 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
- Anything that affects your health

If you agree, your PHI may be shared by:

- 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

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 Minnesota Patient Assistance Program 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 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 12307, La Jolla, CA 92039, 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

If you would like to opt out of the program or make changes to your enrollment:

- You can stop sharing your PHI with us or change what you share by calling us at **1-855-447-8412**, or by writing us at PO Box 12307, La Jolla, CA 92039

I have read and agree to the Patient HIPAA Authorization.
By signing this Authorization, I represent that I am the Authorized Representative for the Patient under 18 years of age. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient or Authorized Representative _____ **Date (MM/DD/YYYY)** _____

Not signing this form will result in a delay in processing your application.

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Privacy Notice:

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.

Your information may be combined with other information that you have previously provided or that Lilly has received. We do not sell personal information.

We may transmit personal information about you to other Lilly affiliates worldwide. These affiliates may in turn transmit personal information about you to other Lilly affiliates. Some of Lilly's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Lilly's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about Lilly's privacy practices, including the basis for transfers and safeguards that Lilly has in place for cross-border transfers of personal information, please contact us at privacy@lilly.com or visit https://www.lilly.com/privacy.

We provide reasonable physical, electronic and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Lilly. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches.

Upon verification, you have the right to request information from us regarding how your personal information is being used and with whom that information is being shared. You also have the right to request to see and get a copy of the personal information that we have about you, request its correction or request its erasure/deletion.

There may be exceptions that apply to your request.

In limited circumstances, you may have the right to have your information transmitted to another entity or person in a machine-readable format.

You will not be discriminated against for exercising any of your rights.

To exercise your rights, you or your authorized representative may submit a request by contacting us using one of the methods listed below.

You may make any of the above requests by contacting us at: The Lilly Answers Center, Lilly USA, LLC, Lilly Corporate Center, Indianapolis, IN 46285 or by calling 1-800-545-5979.

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).

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