Verzenio Continuous Care™ Enrollment Form

DIRECTIONS FOR OFFICE STAFF: Please fax all pages with **PRESCRIBER AND PATIENT SIGNATURE** to **1-855-545-5957**
For questions or concerns, please call Verzenio Continuous Care at **1-844-VERZENIO** (1-844-837-9364)

Verzenio® abemaciclib
50 | 100 | 150 | 200 mg tablets

Please see the following Verzenio Continuous Care services below and check off the programs you wish to enroll in.
All Verzenio Continuous Care services require patient and prescriber signatures. Please remember to sign in the appropriate sections.

1. Verzenio Continuous Care patient support services

☐ **MyFastRx (Accelerated Initiation Program)**
The patient's first month's supply of Verzenio is free and can be shipped directly to her home in as early as 48 hours.
Note: MUST fill out sections 2, 4–11. Refer to eligibility requirements in section 10.

☐ **Send free anti-diarrheal (72 loperamide pills) to the patient** or ☐ **Do not send free anti-diarrheal (loperamide) to the patient**

☐ **Ongoing Support for Verzenio**
Personalized support for patients taking Verzenio, such as 1-on-1 check-ins with a Companion in Care™* throughout treatment.
By selecting this service, I agree to the Ongoing Support Enrollment Consent described in section 9.
*The Companion in Care is not a doctor or nurse, or a substitute for a medical professional; the Companion in Care will direct the patient to her healthcare provider for medical advice.

☐ **Benefits Investigation and Field Reimbursement Support** or ☐ **Field Reimbursement Support Only**
Note: MUST fill out all sections except section 10. **Note:** If Field Reimbursement Support Only is selected, the line below MUST be filled out.

SPECIALTY PHARMACY OR INSTITUTION/IN-OFFICE DISPENSER WHERE PRESCRIPTION WAS SENT (Find a specialty pharmacy that dispenses Verzenio at verzenio.com):

_____

2. Patient Information (Please complete this section in full)

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

Address _____ City _____ State _____ ZIP Code _____

Email _____ Preferred Phone† _____ _____ _____ Preferred Language ☐ English ☐ Spanish

†By providing my mobile telephone number and signing this form, I agree to receive automated and/or prerecorded calls and texts about Verzenio Continuous Care, and I understand that no purchase is necessary to receive these calls or texts.

3. Primary Insurance Information (If Benefits Investigation is selected, please complete this section in full)

Complete the following insurance information

OR

Attach a copy of the policyholder's prescription insurance card (front and back)

☐ No insurance coverage

Primary Insurance Company _____ Cardholder _____

Insurance Company Phone _____ Policy # _____ Group # _____

Prescription Insurance Plan _____

Rx BIN _____ PCN _____

4. Prescriber Information (Please complete this section in full)

Name (First, Last) _____ Office/Clinic/Institution Name _____

Address _____

City _____ State _____ ZIP Code _____ Office Contact E-mail _____ Fax _____

NPI # _____ Group Tax ID # _____

Office Contact Name _____ Office Contact Phone _____

5. Clinical Information (ICD-10 Code) (Please complete this section in full)

Primary Diagnosis Code _____ Secondary Diagnosis Code _____

6. Verzenio Prescription Information

☐ 50-mg tablets (1 x 50 mg) orally twice daily ☐ 150-mg tablets (1 x 150 mg) orally twice daily

☐ 100-mg tablets (1 x 100 mg) orally twice daily ☐ 200-mg tablets (1 x 200 mg) orally twice daily

Quantity to be dispensed:
☐ 28 days ☐ 56 days

☐ MyFastRx (28-day supply only)

7. 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, the prescription complies with my state-specific prescribing requirements, and I appoint Lilly as my agent for the limited purpose of conveying this prescription to the dispensing pharmacy.

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

_____ _____ _____
DISPENSE AS WRITTEN **SUBSTITUTION/BRAND EXCHANGE PERMITTED** **DATE (MM/DD/YYYY)**

IMPORTANT: Don't forget the patient signature at the end of this form.

8. What to Know About Verzenio Continuous Care

Your healthcare provider has talked with you about using Verzenio, an Eli Lilly and Company medicine. Verzenio Continuous Care was created to help you have a positive experience as you get started with and use this medicine. Verzenio Continuous Care offers personalized support to patients at no charge. For the rest of this form, "Lilly" and "we" or "us" will stand for Eli Lilly and Company, its affiliates, agents, representatives, business partners, and service providers.

9. Ongoing Support Enrollment Consent

The Ongoing Support Services included in Verzenio Continuous Care provide support after you've received your medication, like check-in calls to answer any questions you might have about Verzenio. As part of your participation in the Ongoing Support Services, 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. Services include:

Contacting you by email, mail, or telephone to provide personalized services, delivered by your Verzenio Continuous Care Team, such as informational and marketing materials; responding to customer service requests and/or questions about your treatment; requesting feedback on your experience with the related products, services, and programs, including market research and medical research; disclosing your enrollment 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 not part of Verzenio Continuous Care. These activities include opportunities to share your story and participate in studies about products and services.

10. MyFastRx Eligibility Requirements

To be eligible for the MyFastRx program, a patient must:

• Be a new Verzenio patient • Be prescribed Verzenio for an FDA-approved indication • Be 18 years of age or older • Be a resident of the United States or Puerto Rico

Please note: This program is provided by Sonexus rather than your in-office dispensary or any other specialty pharmacy your patient may later use. Verzenio can be shipped to the patient within 48 hours of the receipt of this form. We will contact your office as soon as she's received her dose so you can begin the process of starting her next month's script.

Terms and Conditions:

- The MyFastRx program allows any patient who has been newly prescribed Verzenio for an FDA-approved indication to receive one free trial of Verzenio
- This free trial is not health insurance and is not contingent upon, or a guarantee of, insurance coverage and will be shipped directly to the patient
- Neither the prescriber, prescriber's institution, pharmacy, pharmacist, or any other person, including the patient, may seek payment or accept reimbursement from any patient, any third-party payer, including any state or federal entity or any private or other insurance plan, or from any other person or entity, for Verzenio supplied under this program, regardless of whether the payer subsequently determines it will cover the product
- If a patient is enrolled in a Medicare Part D plan, the prescriber must notify the patient that they must not attempt to have this prescription or any costs associated with it counted as any portion of true out-of-pocket ("TrOOP") costs for prescription drug calculations
- Product provided pursuant to this program may not be sold, traded, or distributed for sale
- No purchase contingency or other obligation accompanies program participation
- Lilly reserves the right to change or end the program at any time without notice. Benefits provided under the program are not transferable

Prescriber: I certify that I understand and agree: 1) To the terms and conditions of MyFastRx; 2) My patient meets the patient Eligibility Requirements of MyFastRx; 3) I am licensed to prescribe the prescription medication identified in this form, and that the prescription complies with my state-specific prescribing requirements; 4) In my medical judgment, Verzenio is clinically appropriate for the patient named above and its use is consistent with the FDA-approved indication; and 5) This supply of Verzenio is specifically for the patient named above.

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

PRESCRIBER SIGNATURE _____ **DATE (MM/DD/YYYY)** _____

11. Patient HIPAA Authorization

Before Verzenio Continuous Care 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 or used as explained below.

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

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
- 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 Verzenio Continuous Care 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 **1-844-VERZENIO** (1-844-837-9364) or by writing us at PO Box 12307, La Jolla, CA 92039. We will follow your wishes after we hear from you

I have read and agree to the Patient HIPAA Authorization above.

PATIENT SIGNATURE _____ **PRINT PATIENT'S NAME** _____ **DATE (MM/DD/YYYY)** _____