Verzenio Prescription and Continuous Care Enrollment Form

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)

1. Patient Information

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

Address _____ City _____ State _____ ZIP Code _____

Email _____ Preferred Language English ☐ Spanish ☐

Primary Phone Number* _____ Secondary Phone Number* _____

*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.

2. Ongoing Support for Verzenio

We created the Verzenio Continuous Care program to give you personalized support while taking Verzenio. Through 1-on-1 check-ins, your Verzenio Continuous Care Team will serve as your dedicated partner throughout every stage of your treatment. They can identify savings opportunities, help you understand what to expect with treatment, answer any questions you may have, and connect you with information and resources about your cancer and treatment.

☐ **By selecting this service, I agree to the Ongoing Support Enrollment Consent described on page 2.**

3. Primary Insurance Information

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. Additional Support Requested for This Patient

CHOOSE ONLY ONE

☐ **Benefits Investigation & Field Reimbursement Support**
Verzenio Continuous Care will research the Patient's insurance and in-network pharmacy options to identify the lowest out-of-pocket cost available for Verzenio and forward the prescription to the pharmacy that the Patient selects. A Field Reimbursement Manager will help triage and troubleshoot access issues on the Patient's behalf.
Note: MUST fill out the "Verzenio Prescription Information" in Section 8

OR

☐ **Field Reimbursement Support Only**
The Patient's prescription has been sent to the specialty pharmacy or institution/in-office listed below for a benefits investigation, so Verzenio Continuous Care will not handle the prescription. A Field Reimbursement Manager will intervene if help is needed resolving access issues on the Patient's behalf.
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 www.verzenio.com)

5. Prescriber Information

Name (First, Last) _____ Practice Name _____

Address _____

City _____ State _____ ZIP Code _____ Phone _____ Fax _____

NPI # _____ Group Tax ID # _____

Office Contact Name _____ Office Contact Phone _____

6. Clinical Information (ICD-10 Code)

Primary Diagnosis Code _____

Secondary Diagnosis Code _____

7. Antidiarrheal Request

☐ Send free loperamide to the Patient — 72 pills ☐ Do not send free loperamide to the Patient

8. Verzenio Prescription Information

☐ 200 mg tablets (1 x 200 mg) orally twice daily ☐ 150 mg tablets (1 x 150 mg) orally twice daily

☐ 100 mg tablets (1 x 100 mg) orally twice daily ☐ 50 mg tablets (1 x 50 mg) orally twice daily

Quantity to Be Dispensed: ☐ 28 days ☐ 56 days

Refills: _____

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)**

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.

Ongoing Support Enrollment Consent

The Ongoing Support Services included in Verzenio Continuous Care provides 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. Disclosing your enrollment and use of these services to your doctors and insurers. Analyzing and/or measuring program performance for future enhancements. Other opportunities and 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.

By checking the corresponding box on the first page under Section 2: Ongoing Support for Verzenio, you consent to your enrollment in Verzenio Continuous Care Ongoing Support as described in this Consent.

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

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
- 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.

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