Lilly Cares Foundation, Inc.

(Temporary Prescription Assistance Program)
P.O. Box 230999 Centreville, Virginia 20120 1-800-545-6962

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PART ONE – PRESCRIPTION INFORMATION: (This blank form may be photocopied for future use.)

Patient Name:____ **Date**:_________________________________

Product Requested (NOT VALID FOR CONTROLLED SUBSTANCES):_________________________________
[If insulin, please specify Iletin®, Humulin® or Humalog® type. If sliding scale, indicate maximum unit daily dosage.]
Evista® (Raloxifene Hydrochloride), Prozac® (Fluoxetine Hydrochloride), Strattera™ (Atomoxetine Hydrochloride), Zyprexa® (Olanzapine), Zyprexa® Zydis® (Olanzapine Orally Disintegrating Tablets).

Dosage: ______________________________ **Sig**:___________________________ **Quantity**:________________
A four-month supply will be supplied unless a lesser amount is requested

Physician Signature:____ **Date**:___________________________
Original Signature Only; No Photocopies or Stamps

PART TWO – PRESCRIBER INFORMATION: (please print clearly)

Physician Name:____ **DEA #:**________________________

Facility Name:____ **Phone**:______________________________

Does patient have access to medication at no charge or at a reduced cost through your facility: Yes_______ No:_________

If yes, what medications are covered?____

Mailing Address:______________________________	**Shipping Address**:______________________________ DO NOT USE P.O. BOX
City:______________________________	**City**:______________________________
State:_______________ **Zip**:_______________	**State**:_______________ **Zip**:_______________

State License No/Expiration Date : ____

PART THREE - PATIENT INFORMATION: (please print clearly)

Patient Name:____ **SSN**:________/______/__________
Last First MI

Address:____ **City**:______________________________

State:_________ **Zip:**_______________ **Date of Birth**:____________________ **Phone**:____________________

Number of people in household:___________ **Total monthly household income: $** ________________________
(all sources for all household occupants – earnings, SSI, SSDI, pension, unemployment, alimony, child support, food stamps, etc.)

Male_________ **Female**_______

If income listed as 0, please explain means of support:____

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Liquid assets: $________________________**Monthly Medical Expenses: $**___________________________
(stocks, bonds, IRAs, checking/savings)

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PART FOUR – INSURANCE INFORMATION

1. Is this patient covered by Medicare: **Yes**__________________ **No**________________________

2. Does this patient have any prescription coverage: Yes__________________ **No**________________________

If yes, please explain:____

3. Has the patient applied for any of the following:

Medicaid - Yes_____________ **No**____________ **Status**____

Supplemental Security Insurance (SSI) Yes___________ **No**__________ **Status**__________________

Social Security Disability (SSDI) Yes___________ **No**__________ **Status**__________________

ATTENTION ZYPREXA APPLICANTS:

If coverage has been denied by any of the above programs,
Please attach the letter of denial with this form.

Patient Authorization and Certification

I authorize Eli Lilly and Company and their consultants to use this information to assess my eligibility for participation in the Lilly Cares program. I understand that while this assistance is free of charge, it is temporary, and I may be asked to reapply at designated intervals. I certify I do not have the ability to pay for my medication and that I have no government or private insurance to help pay for my medication.

Patient (or guardian) Signature:____ **Date:**_____________________

DIRECTIONS FOR COMPLETING APPLICATION

PROVIDERS:

Please complete Parts 1 and 2 of the application. Please print clearly.
Original signatures only, no stamps or photocopies.
Product will only be delivered to a street address, not a P.O. Box.

PATIENTS:

Please complete Parts 3 and 4 of the application. Please print clearly.
Number of people in household includes EVERYONE living in the home.
Enter the DOLLAR amount for the following categories: Monthly Household Income, Household Liquid Assets.
Household income includes the following: Social Security, disability, Supplemental Security Income (SSI), unemployment, workman's compensation benefits, child support, alimony, loans, Pensions, interest, etc.

AN INCOMPLETE FORM WILL RESULT IN A DELAY IN PROCESSING THIS REQUEST