Lilly Cares Foundation, Inc.

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

****

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:_____

_____

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

Continued on back

Continued:

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