Lilly Support Services™

PATIENT ENROLLMENT SECTION
Oncology Infused Products

PUBLISHED 12/2025

HAVE YOUR PATIENT SCAN to add Lilly Support Services™ for Oncology Infused Products to their phone contacts

SUBMIT COMPLETED PAGES 1-4 VIA FAX AT 1-877-366-0585.
For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday, 8am-10pm ET.

THIS PAGE MUST BE SUBMITTED

Section 1: Patient Information

Patient Name (First, MI, Last) _____ **Date of Birth** (MM/DD/YYYY) _____

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

US or Puerto Rico Resident ☐ Yes ☐ No **Gender** ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone* (000-000-0000) _____ **Email** _____

☐ ***By checking the box, 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 receiving goods and services. Message and data rates may apply.**

☐ By checking the box, I agree to be contacted to: provide feedback on my experience with the related products, services, and programs; to share my story; and, to participate in market and medical research studies about products and services.

Section 2: Insurance Information

Must select one of the following: ☐ **No Insurance Coverage** ☐ **Copy of Policyholder's Insurance Card (Front and Back) Is Attached** ☐ **Provide Information Below**

Primary Medical Insurance Company _____

Primary Insurance Company Phone (000-000-0000) _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

RX BIN _____ **PCN** _____

Secondary Medical Insurance Company _____

Secondary Insurance Company Phone (000-000-0000) _____ **Secondary Cardholder Name** _____

Secondary Policy/ID _____ **Secondary Group #** _____

Section 3: Service Selection

Please select if you would like to enroll by checking the corresponding checkbox below. By enrolling in any of these services below, you are agreeing to the Terms of Participation and consenting to the collection of your information, inclusive of health information as described in our Privacy Notice.

☐ **1. Lilly Oncology Infused Products™ Savings Card**

SAVINGS CARD ELIGIBILITY (must confirm the below statements)

☐ I confirm that I am NOT enrolled in a government-funded healthcare program, including without limitation, Medicaid, Medicare, Medicare Part D, Medicare Advantage, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state prescription drug assistance program

☐ I confirm that I have reviewed and agree to the Terms and Conditions on Page 5 and attest that I am eligible to participate in this program

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using CYRAMZA®/ERBITUX®, an Eli Lilly and Company medicine. Lilly Support Services™ for Oncology Infused Products offers personalized support to Patients at no charge and was created to help you have a positive experience as you get started with and use this medicine. By checking the corresponding optional box above, you consent to your enrollment into Lilly Support Services™ for Oncology Infused Products. As part of your participation in Lilly Support Services™ for Oncology Infused Products, you understand and authorize Lilly USA, LLC to retain and use your personal information for the purposes described in this form. Eli Lilly and Company, Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "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. The Lilly Support Services™ for Oncology Infused Products Support team can contact you by email, mail or telephone to provide personalized services and information and materials directly related to your condition and therapy; responding to customer service requests and/or questions about your treatment; disclosing your enrollments 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 part of Lilly Support Services™ for Oncology Infused Products. Your personal information, including information that may be related to your health, is needed to fulfill your request. To cancel your participation in the program, please contact us at 1-800-LillyRx (1-800-545-5979) Monday-Friday, 8am-10pm ET. For information about Lilly's privacy practices, please see our Privacy Statement at https://privacynotice.lilly.com and the Consumer Health Privacy Notice at https://www.lillyhub.com/legal/lillyusa/CHPN.html.

By signing below, I certify that I have read and accepted the Lilly Oncology Infused Products Savings Card Program Terms and Conditions on page 5

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

Not signing this form will result in an incomplete submission and a delay in requested services

Printed Name of Patient _____ **Patient's DOB (MM/DD/YYYY)** _____

Lilly A MEDICINE COMPANY

Lilly Support Services™

PRESCRIBER ENROLLMENT SECTION
Oncology Infused Products

PUBLISHED 12/2025

THIS PAGE MUST BE SUBMITTED

Section 4: Prescriber information

Prescriber Name (First, Last) _____ **NPI #** _____

Practice Name _____ **Office Phone (000-000-0000)** _____

Office Fax (000-000-0000) _____ **Office Address** _____

Office City _____ **Office State** _____ **Office Zip** _____ **Group Tax ID** _____

Office Contact Name _____ **Office Contact Phone (000-000-0000)** _____

Office Contact Email _____ **Secondary Office Contact** _____

Section 5: Diagnosis

Name of Patient (First, MI, Last) _____

Patient DOB (MM/DD/YYYY) _____ **Patient Address** _____

Patient City _____ **Patient State** _____ **Patient Zip** _____

Diagnosis:

ICD-10 Code _____

Section 6: HCP Service Selection & Prescription

Benefits Investigation Support (select one)

☐ **Benefits Investigation - (FDA Approved and Compendia Use)** Lilly Support Services™ for Oncology Infused Products will research the Patient's insurance options to help identify the lowest out-of-pocket cost available for the prescribed medication. A Lilly Support Services™ for Oncology Infused Products representative will help triage and troubleshoot access issues on the Patient's behalf. This includes Prior Authorization and Appeals Research. **IF CHECKED, MUST FILL OUT SECTION BELOW.**

☐ **Specialty Pharmacy Conducted Benefits Investigation**– For Qualified, Commercially Insured Patients Only – **IF CHECKED, PATIENT MUST REQUEST A SAVINGS CARD AND PROVIDE THEIR SIGNATURE ACCEPTING THE SAVINGS CARD TERMS AND CONDITIONS FROM PAGE 1.**

Specialty Pharmacy where prescription was sent

_____

Specialty Pharmacy Phone Number (000-000-0000)

_____

Valid enrollment includes: Treatment Setting, Product Prescribed, and Start Date

Treatment Setting: ☐ **Physician's Office** ☐ **Hospital Outpatient**

Name and Address of Hospital (if applicable) _____

Hospital NPI (if applicable) _____ **Hospital Tax ID #** (if applicable) _____

You must select the Product Prescribed

Product Prescribed: PLEASE SELECT ONLY ONE PRODUCT PER FORM

☐ **CYRAMZA®** ☐ **ERBITUX®**

If diagnosis is metastatic colorectal, please choose from the following:

☐ **No Mutation** ☐ **KRAS Wild Type Disease** ☐ **RAS Mutation**

☐ **No Testing Done/Unknown Status**

Start Date

_____

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; 5) I am licensed to prescribe the prescription medication identified in this form; 6) Treatment for Patients enrolled in the Lilly Oncology Infused Products Copay Program is for an FDA-approved indication or an indication medically supported by CMS recognized Compendia; and 7) to the best of my knowledge, the Patient meets the insurance and residency requirements (for those applying for the Lilly Oncology Infused Products Copay Program). **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE.** Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

☐ By checking this box, I confirm that the Patient has provided express consent to be contacted by automated text messaging from Eli Lilly and Company, and parties working on their behalf, to complete enrollment in the Patient Support Program.

_____ _____

Prescriber Signature **Date Signed (MM/DD/YYYY)**

Not signing this form will result in an incomplete submission and a delay in requested services

Lilly A MEDICINE COMPANY

Lilly Support Services™

HIPAA AUTHORIZATION

PUBLISHED 12/2025

THIS PAGE MUST BE SUBMITTED

You have selected Eli Lilly and Company ("Lilly") to coordinate certain services related to your health and to provide information related to your health (Lilly's "Programs and Services"). In order for Lilly to offer the Programs and Services, Lilly may need to obtain or exchange your protected health information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") from your Health Care Entities (as defined below). PHI can be inclusive of "sensitive data" as defined by applicable U.S. privacy laws. After your PHI has been released to Lilly, it is no longer covered by HIPAA. By signing this form, you understand and authorize your Health Care Entities to share your PHI with Lilly and use as explained below.

PHI includes the following individually identifiable information:

- Information about your health insurance or benefits, including how much coverage you have
- All relevant records about your treatment, including medication histories and prescriptions
- Information about your payment for treatment, including any insurance coverage
- Whether you're staying on your medicine or treatment

If you agree, your PHI may be collected from and shared by these entities (together "Health Care Entities"):

- 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 on behalf of your healthcare providers, pharmacies and healthcare plans

How Your PHI Will Be Used

Your PHI will be used to enroll you in, provide you with, and operate and administer the Programs and Services, consistent with Lilly's Privacy Statement and Consumer Health Privacy Notice, including to:

- understand how much of your Lilly treatment is covered by your insurance
- help you find ways to afford such treatment
- track the shipment, receipt, and use of your Lilly treatment and Programs and Services
- share information with your Health Care Entities and communicate with them regarding Lilly Programs and Services
- contact you about Lilly Programs and Services related to your health needs
- measure Lilly Programs and Services' performance in order to make improvements and drive business decisions and metrics
- de-identify your data for analytics including reports about Health Care Entities' use of Lilly Programs and Services.

Lilly A MEDICINE COMPANY

THIS PAGE MUST BE SUBMITTED

Other things you should know about how we may use and share your PHI:
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 Lilly and its wholly owned subsidiaries ("Lilly" or "we") and/or entities or persons that work on behalf of, or in partnership with, Lilly but are not Lilly employees ("Third Parties").

- You don't have to give permission to share your PHI with Lilly to receive treatment from your Health Care Entities, your prescription from your pharmacy, or benefits from your healthcare plan, but Lilly Programs and Services may not be able to help you without your Authorization.
- Your Health Care Entities may receive compensation from 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.
- Your signed authorization to share and use your PHI lasts for the duration of your participation in Lilly Programs and Services from the date of your signature or earlier as required by state law. In any case, you may revoke this Authorization for Lilly Programs and Services and you may request to obtain PHI from your Health Care Entities at any time by writing to PO Box 501847, San Diego, CA 92150. Your revocation of this Authorization will not have any effect on any uses or disclosures of your PHI that occurred prior to Lilly's receipt of your revocation.
- **Your revocation of this Authorization will be effective when your Health Care Entities receive notice of your cancellation or revocation and will not apply to any information shared with Lilly prior to receipt of the notice.**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my Health Care Entities to disclose my PHI and sensitive data for the purposes as described in this HIPAA Authorization. This HIPAA Authorization replaces any prior HIPAA Authorizations that I may have provided at a specific program level.

By signing this form, I attest that I have read and agree to the Patient HIPAA Authorization. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient _____
Not signing this form will result in an incomplete submission and a delay in requested services

Printed Name of Patient _____

Signature Date (MM/DD/YYYY) _____

DOB (MM/DD/YYYY) _____

Lilly Support Services™

PUBLISHED 12/2025

SAVINGS CARD TERMS AND CONDITIONS

By enrolling in the Lilly Oncology Infused Products Savings Card Program ("Program") and using the Lilly Oncology Infused Products Savings Card ("Card"), you attest that you meet the eligibility criteria, agree to, and will comply with the terms and conditions described below:

Eligibility:

(1) You have been prescribed one of the following Lilly Oncology medicines ("Covered Medicine") for an approved use consistent with FDA-approved product labeling: Cyramza® (ramucirumab) or Erbitux® (cetuximab);

(2) You are enrolled in a commercial drug insurance plan and have coverage for your prescribed Covered Medicine, but your insurance does not cover the full cost of your prescribed Covered Medicine (i.e., you have a co-pay or coinsurance obligation);

(3) You are not enrolled in any state, federal, or government funded healthcare program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medicare Advantage, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state prescription drug assistance program;

(4) You are a resident of the United States or Puerto Rico; and

(5) You are 18 years of age or older.

Card Terms and Conditions

You must (a) have commercial drug insurance that covers your prescribed Covered Medicine, but your insurance does not cover the full cost and (b) have a prescription for an approved use consistent with FDA- approved product labeling to pay as little as $25 for each infusion of your prescribed Covered Medicine. The Program will cover your co-pay or coinsurance for your prescribed Covered Medicine less $25, up to a maximum monthly savings of up to wholesale acquisition cost plus usual and customary fees and a separate maximum annual savings of up to $25,000 per calendar year. Card may be used for a maximum of up to 12 infusions per calendar year. After the monthly and/or annual maximum savings are reached, you will be responsible for paying any remaining monthly/annual out-of-pocket costs. Program may provide support for infusions with a date of service that falls within 120 days prior to the date the enrollment form is received by the Program.

To receive Program savings, your healthcare provider must submit a claim for coverage to your medical insurance provider. If your medical insurance provider does not cover the full cost of the claim, your healthcare provider must then submit an Explanation of Benefits (EOB) form and a CMS 1450 or 1500 form to www.LillyOncologyPortal.com within 180 days of the infusion date of your prescribed Covered Medicine. The submitted form must include the name of the insurer and plan and demonstrate that a Covered Medication was the medication administered. You understand and agree that Lilly will make a payment of your Program savings on your behalf to your healthcare provider. Subject to Lilly USA, LLC's ("Lilly") right to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2026.

Additional Terms and Conditions

If you have an insurance plan that is participating in an alternate funding program ("AFP") that requires you to apply to the Lilly Oncology Infused Products Savings Card Program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of your prescribed Covered Medicine, you are not eligible for and are prohibited from using the Lilly Oncology Infused Products Savings Card Program. AFPs include programs where coverage, reimbursement, or patient out of pocket costs for a product in some way vary based on the availability of a manufacturer co-pay program. AFPs may modify, delay, deny, restrict, or withhold insurance benefits or coverage from patients, or exclude Lilly Products from coverage contingent upon a member's use of the Lilly Oncology Infused Products Savings Card Program. You agree to inform the Lilly Oncology Infused Products Savings Card Program if you are or become a member of such an alternate funding program. You are responsible for any applicable taxes, fees, and any amount that exceeds the monthly or annual maximum savings. Monthly and annual maximums are set at Lilly's sole and absolute discretion and may be changed with or without notice at any time for any reason. At its sole discretion and with or without notice, Lilly may reduce, eliminate, or otherwise modify the Card savings for any reason, including but not limited to if your commercial drug insurance plan imposes additional requirements which limits or prevents you from receiving coverage for your prescribed Covered Medicine, only allows partial coverage for your prescribed Covered Medicine, removes coverage for your prescribed Covered Medicine and requires you to utilize the Card, does not provide a material level of financial assistance for the cost of your prescribed Covered Medicine, or does not apply Card payments to satisfy your co-payment, deductible, or coinsurance for your prescribed Covered Medicine.

Program savings are limited to the co-pay or coinsurance costs for your prescribed Covered Medicine only, subject to monthly and annual maximum savings, outlined above. The Program will not cover, and shall not be applied toward, the cost of any dosing procedure, any other healthcare provider service or supply charges or other treatment costs, or any costs associated with a hospital stay. Participation in the Program requires a valid patient HIPAA authorization to enroll in the Program. Card savings are not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. You must meet the Card eligibility criteria, terms and conditions every time you use the Card. If at any time you begin receiving coverage under any state, federal, or government funded healthcare program, you understand that you will no longer be eligible for the Lilly Oncology Infused Products Savings Card Program and agree to call Lilly Support Services for Oncology Infused Products at 1-800-545-5979 to stop participation. You may not seek reimbursement from your health insurance, any third party, or any health savings, flexible spending, or other healthcare reimbursement accounts, for any amount of the savings received through the Card. By utilizing the Card, you agree that if you are required to do so under the terms of your insurance coverage for this prescription or are otherwise required to do so by law, you will notify your Insurance Carrier of your redemption of the Card. Card savings cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, incentive, or similar offer involving your prescribed Covered Medicine. You agree that this Card savings is intended solely for the benefit of you, the patient, and that the Card benefits are non-transferable. It is prohibited for any person to sell, purchase, or trade; or to offer to sell, purchase, or trade, or to counterfeit the Card. **THIS CARD IS NOT INSURANCE**. Lilly has the sole right to interpret and apply Card eligibility criteria, and terms and conditions. Card eligibility, and terms and conditions may be terminated, rescinded, revoked, or amended by Lilly at any time without notice and for any reason. Lilly's sole discretion to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions includes the right to terminate any individual Card if Lilly determines, in its sole discretion, that a patient does not satisfy the Card's eligibility criteria or is using or has attempted to use the Card inconsistently with these Terms and Conditions. Eligibility criteria, and terms and conditions for the Lilly Oncology Infused Products Savings Card Program may change from time to time; the most current version can be found at https://oncologysupport.lilly.com/cyramza-financial-support or https://oncologysupport.lilly.com/erbitux-financial-support.You may be required to obtain a new Card, including if any Card terms and conditions have been terminated, rescinded, revoked, or amended by Lilly. Card void where prohibited by law. Subject to Lilly USA, LLC's right to terminate, rescind, revoke or amend Card eligibility criteria and/or Card terms and conditions which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2026.

Lilly A MEDICINE COMPANY