Lilly Support Services™

PATIENT ENROLLMENT SECTION

Kisunla™ (donanemab-azbt)
injection for IV infusion

PUBLISHED 01/2025

OFFICE: Complete the entire form and submit pages 1-4 to Lilly Support Services™ via fax at 1-844-731-2697. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Section 1: Patient and Alternate Contact Information

Patient Name (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

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

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

Phone* _____ **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.

You may provide the name of an Alternate Contact with whom you authorize Lilly Support Services™ to speak on your behalf about your participation in this program. This person can provide or receive your personal information as necessary until you terminate their authority. By providing the information below, you certify that the individual is aware and agrees that you will provide their name and contact information to Lilly Support Services™ for the purpose of serving as an Alternate Contact. You can change or remove the Alternate Contact at any time by calling Lilly Support Services™ at 1-800-LillyRx (1-800-545-5979).

(Optional) Alternate Contact (First, Last) _____ **Relationship to Patient** _____

Alternate Contact Phone _____ **Alternate Contact Email** _____

If an Alternate Contact is listed in this section, the Primary Contact should be (select one): ☐ **Patient** ☐ **Alternate Contact**

Please complete the contact preferences below for the Primary Contact (whether that is the Patient or Alternate Contact):

Preferred Contact: ☐ Phone Call ☐ Text ☐ Email **Best Time To Call:** ☐ Morning ☐ Afternoon ☐ Evening

Section 2: Primary 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**

Must select your type of insurance: ☐ **Medicare** ☐ **Medicaid** ☐ **Commercial** ☐ **Other** _____

Primary Medical Insurance Company/Provider _____

Insurance Company Phone # _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

Section 3: Secondary Insurance Information

Must select one of the following: ☐ **No Secondary Insurance Coverage (Proceed to the next section)**

☐ **Copy of Policyholder's Insurance Card (Front and Back) Is Attached** ☐ **Provide Information Below**

Must select your type of insurance: ☐ **Medicare** ☐ **Medicaid** ☐ **Commercial** ☐ **Other** _____

Secondary Medical Insurance Company/Provider _____

Insurance Company Phone # _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

Section 4: Terms of Participation and Program Disclosures

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using Kisunla™, an Eli Lilly and Company medicine. Lilly Support Services™ for Kisunla™ 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 signing and submitting this form, you consent to your enrollment into Lilly Support Services™. As part of your participation in Lilly Support Services™, 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™ 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™. 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) Mon - Fri, 9am - 6pm 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.

Please continue to the next page.

Lilly

Lilly Support Services™

PATIENT HIPAA AUTHORIZATION

PUBLISHED 01/2025

OFFICE: Complete the entire form and submit pages 1-4 to Lilly Support Services™ via fax at 1-844-731-2697. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Before Lilly Support Services™ for Kisunla™ can start helping you, Lilly may ask for some information about you and your health from your Health Care Entities (as defined below). This is known as your Protected Health Information, or PHI. By signing this form, you understand and agree that your PHI may be shared with or used by Lilly as explained below.

PHI includes information like:

- Your health insurance or benefits, including how much coverage you have
- All records about your treatment
- Whether you're staying on your medicine or treatment

If you agree, your PHI may be 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

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. Your PHI will be released to Eli Lilly and Company and Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "Lilly").
- 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 Lilly Support Services™ 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 with others by Lilly
- Your signed permission to share and use your PHI lasts for 3 years from the date of your signature unless you are a resident of Maryland, Maine, or Montana, in which case the permission will last for 1 year from the date of your signature. In either case, you may revoke your permission before then by writing to 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067, which will preclude reliance on the authorization after the date your written revocation is received
- Your healthcare providers (such as pharmacies) may be paid by 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
- **You can stop sharing your PHI with us or change what you share by calling us at 1-800-LillyRx (1-800-545-5979) or by writing us at 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067**
- **Your cancellation or 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 by your Health Care Entities prior to the time those Health Care Entities receive notice**

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 _____ **Date Signed (MM/DD/YYYY)** _____

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

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