Lilly Support Services™

PATIENT ENROLLMENT SECTION
EBGLYSS™ (lebrikizumab-lbkz) Dermatology

UPDATED 09/2024

OFFICE: Complete the entire form and submit pages 1, 3-4 to Lilly Support Services™ for EBGLYSS™ via fax at 1-833-324-0051 or upload online at https://patientsupportnow.org and code: 8333240051. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 8am – 10pm ET.

Section 1: Patient Information

Patient Name _____ **DOB** _____ **Gender** _____ **State of Residence** _____

Authorized Representative Name _____ **DOB** _____ **Relationship to Patient** _____

Address _____

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

Email _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____

Home Phone _____ **Mobile Phone*** _____

☐ *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 Prescription Insurance Company _____

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

Policy/ID _____ **Group #** _____

RX BIN _____ **PCN** _____

Section 3: Service Selection

Please select which options you would like to enroll in by checking the corresponding checkboxes 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 under the Privacy Notice on page 5.

☐ **1. EBGLYSS™ Savings Card**

SAVINGS CARD ELIGIBILITY (must confirm the below statements in order to be eligible)

☐ I confirm that I am a resident of the United States or Puerto Rico who is 18 years of age or older

☐ 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

☐ **2. Sharps Disposal Support**

☐ **3. I am requesting enrollment in EBGLYSS™ Injection Training**

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using EBGLYSS™, an Eli Lilly and Company medicine. Lilly Support Services™ for EBGLYSS™ 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 boxes above, you consent to your enrollment into Lilly Support Services™ for EBGLYSS™. As part of your participation in Lilly Support Services™ for EBGLYSS™, 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 EBGLYSS™ 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 EBGLYSS™. 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, 8am -10pm ET. For information about Lilly's privacy practices, please see our Privacy Statement at https://privacynotice.lilly.com.

Please continue to the next page.

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

Card Eligibility:

(1.) You have been prescribed EBGLYSS (lebrikizumab-lbkz) consistent with FDA-approved product labeling;
(2.) You are enrolled in a commercial insurance plan;
(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:

For patients with commercial insurance coverage for EBGLYSS: You must have commercial insurance that covers EBGLYSS and a prescription consistent with FDA-approved product labeling to pay as little as $5 for a 1-month prescription fill of EBGLYSS. Month is defined as 28 days. Card must be first used by no later than 12/31/2025. Card savings are subject to a maximum monthly savings of wholesale acquisition cost plus usual and customary pharmacy charges and a separate maximum annual savings of up to $9,450 per calendar year. Participation in the Program requires a valid patient HIPAA authorization upon enrollment into the Program. 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 12/31/2027 or 24 months after you first use the Card, whichever comes first.

For patients with commercial insurance who do not have coverage for EBGLYSS: You must have commercial insurance that does not cover EBGLYSS and a prescription consistent with FDA-approved product labeling to pay as little as $25 for a 1-month supply of EBGLYSS. Month is defined as 28 days. Card must be first used by no later than 12/31/2025. Participation in the $25 Program requires submission of a prior authorization (PA) and a coverage denial outcome prior to first prescription fill. For patients who enrolled in the $25 Program on or before May 31, 2025, to remain eligible for continued enrollment in the $25 Program, a new PA must be submitted with a denial outcome received by August 1, 2025, and by each August 1st thereafter and as required by Lilly at its sole discretion. For patients who enrolled in the $25 Program on or after June 1, 2025, to remain eligible for continued enrollment in the $25 Program, a new PA must be submitted with a denial outcome received by August 1, 2026, and by each August 1st thereafter and as required by Lilly at its sole discretion. Card savings are subject to a maximum monthly savings and a separate maximum annual savings. Participation in the Program requires a valid patient HIPAA authorization to remain in the Program. 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 12/31/2027 or 24 months after you first use the Card, whichever comes first.

If you have an insurance plan that is participating in an alternate funding program (AFP) that requires you to apply to the EBGLYSS 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 EBGLYSS, you are not eligible for and are prohibited from using the EBGLYSS 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 EBGLYSS Savings Card Program. You agree to inform EBGLYSS Savings Card Program if you are or become a member of such an alternative funding program. You are responsible for any applicable taxes, fees, and any amount that exceeds the monthly or annual maximum Card savings. Monthly and annual maximum savings 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 EBGLYSS, only allows partial coverage for EBGLYSS, removes coverage for EBGLYSS and requires you to utilize the Card, does not provide a material level of financial assistance for the cost of EBGLYSS, or does not apply Card payments to satisfy your co-payment, deductible, or coinsurance for EBGLYSS. 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. Card activation is required. 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 EBGLYSS. You agree that this Card savings is intended solely for the benefit of you, the patient, and that the Card benefits are nontransferable. It is prohibited for any person to sell, purchase, or trade; or to offer to sell, purchase, or trade, or to counterfeit the Card. The 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 EBGLYSS Savings Card Program may change from time to time; the most current version can be found at https://www.EBGLYSS.lilly.com/savings-support#termsandconditions. 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'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, the Card expires and savings end on 12/31/2027 or 24 months after you first use the Card, whichever comes first.

Please continue to the next page.

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PATIENT HIPAA AUTHORIZATION

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Before Lilly Support Services™ for EBGLYSS™ 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™ for EBGLYSS™ 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 PO Box 221349, Charlotte, NC 28222, 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 PO Box 221349, Charlotte, NC 28222**
- **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. By signing this Authorization, I represent that I am the Authorized Representative for the Pediatric Patient. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient or Authorized Representative _____ **Date Signed (MM/DD/YYYY)** _____

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

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

Lilly

Lilly Support Services™

PRESCRIBER ENROLLMENT SECTION
EBGLYSS™ (lebrikizumab-lbkz) Dermatology

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UPDATED 09/2024

Section 4: Prescriber information

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

Practice Name _____ **Phone** _____ **Fax** _____

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

Office Contact Name _____ **Office Contact Phone** _____

Office Contact Email _____

Collaborating Physician _____ **NPI #** _____ **Group Tax ID** _____

Section 5: Diagnosis

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

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

Diagnosis:

☐ **L20.9, Atopic dermatitis, unspecified** ☐ **L20.89, Other atopic dermatitis** ☐ **Other ICD-10-CM Code** _____

Section 6: HCP Service Selection & Prescription

Benefits Investigation Support (select one choice)

☐ **Specialty Pharmacy Conducted Benefits Investigation**–Specialty Pharmacy where prescription was sent _____
Specialty Pharmacy Phone Number _____

OR

☐ **Lilly Conducted Benefits Investigation**–Lilly Support Services™ for EBGLYSS™ will research the Patient's insurance and in-network Specialty Pharmacy options to help identify the lowest out-of-pocket cost available for EBGLYSS™ and will forward the prescription to the Specialty Pharmacy that the Patient selects. A Lilly Support Services™ for EBGLYSS™ representative will help triage and troubleshoot access issues on the Patient's behalf. **IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION BELOW.**

EBGLYSS™ Dermatology Prescription — Fill out corresponding prescription below and sign at the bottom of page

Device Type – EBGLYSS™ (lebrikizumab-lbkz) 250mg/2mL injection ☐ **Pre-Filled Pen** ☐ **Pre-Filled Syringe**

	Quantity	Day Supply	Refills
1) INITIAL DOSE (FOR PATIENTS 12-17 YEARS OLD, MUST BE ≥ 40kg):			
☐ **Initial Dose:** 2 x 250 mg (500 mg total) by subcutaneous injection at week 0 and week 2 (choose if no samples given)	4 pens/syringes	28	0
OR			
☐ **Initial Dose:** 2 x 250 mg (500 mg total) by subcutaneous injection at week 2 (choose if 2 samples given)	2 pens/syringes	14	0
OR			
☐ **Initial Dose:** Samples given for Weeks 0 and 2 - no starting dose needed from Specialty Pharmacy	N/A	N/A	0
2) INDUCTION DOSE (FOR PATIENTS 12-17 YEARS OLD, MUST BE ≥ 40kg):			
☐ **Induction Dose:** 250 mg by subcutaneous injection every 2 weeks until week 16 or later, when adequate clinical response is achieved **If additional Induction Dosing (Q2W) is needed, call new Induction Dose to the Specialty Pharmacy*	2 pens/syringes	28	2
3) MAINTENANCE DOSE (FOR PATIENTS 12-17 YEARS OLD, MUST BE ≥ 40kg):			
☐ **Maintenance Dose:** 250 mg by subcutaneous injection every 4 weeks	1 pen/syringe	28	____

You must select Dosing

Prior Treatment Failures, Contraindications, Intolerances, or Allergies (select all that apply)

☐ Dupixent® ☐ Adbry® ☐ RINVOQ® ☐ EUCRISA® ☐ CIBINQO™ ☐ Other _____

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, Lilly USA, LLC, their 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 purposes of conveying this prescription by facsimile only to the dispensing pharmacy. I understand that by signing this form, I am requesting support from Eli Lilly and Company for Patients receiving EBGLYSS™ pursuant to an FDA approved indication.
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.

Dispense as written **May substitute/brand exchange permitted** **Date Signed (MM/DD/YYYY)**

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

 UPDATED 09/2024

Privacy Notice:

This Privacy Notice ("Notice") is intended to supplement the Eli Lilly and Company Privacy Statement (https://privacynotice.lilly.com) and the Consumer Health Privacy Notice (https://www.lillyhub.com/legal/lillyusa/CHPN.html) that can be accessed in the footers of Lilly's websites. This Notice is to provide you with information about the personal information, including health information, we may collect, use, disclose or otherwise process, and your rights and choices with respect to your information.

The categories of health information we collect will depend on how you interact with Lilly Services and the information you choose to provide. We may collect:

- Health conditions, treatments, diseases, or diagnosis
- Social, psychological, behavioral, and medical interventions
- Health-related surgeries or procedures
- Use or purchase of prescribed medication
- Bodily functions, vital signs, symptoms, or measurements of other types of consumer health data
- Diagnoses or diagnostic testing, treatment, or medication
- Reproductive or sexual health information
- Biometric data
- Genetic data
- Data that identifies a consumer seeking health care services
- Other information that may be used to infer or derive data related to the above or other health information.

With your consent, we may use the health information we collect for the following purposes, as further described in our privacy statements:

- Providing Services and support.
- Analytics and improvement.
- Customization and personalization.
- Marketing and advertising.
- Security and protection of rights.
- Legal proceedings and obligations.
- General business and operational support.

Lilly does not sell or share your health information with third parties without your consent or authorization. We may disclose health information to our processors for our business purposes or at your direction to provide you with products and Services that you request.

We may use and save your personal information to meet legal or regulatory obligations that are in the legitimate interest of Lilly, to fulfill legitimate and lawful business purposes in accordance with Lilly's record retention policies and applicable laws and regulations, and to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests.

Some of this personal information may be considered sensitive under applicable laws, such as information about your health or medical diagnosis and demographic information collected in some circumstances, such as race, ethnic origin, and sexual orientation. We may process your sensitive PI with your consent, or as otherwise permitted by law.

Upon verification, you have rights with respect to the collection, use and storage of your information. These rights may include access to your information and how it is being used or shared, the right to correct, delete or limit use of your information or to withdraw consent for us to collect and use your information. There may be certain exceptions and limitations that apply to your request including the right to have your information transmitted to another entity or person in a machine-readable format. To exercise your rights, you or your authorized representative may submit a request to datarights@lilly.com or 1-800-Lilly-Rx (1-800-545-5979). You will not be discriminated against for exercising any of your rights. You may be entitled, in accordance with applicable law, to appeal a refusal to take action on your request. To do so, please contact us by using one of the methods listed here or in How to Contact Us section of the online Privacy Statement.

If you wish to raise a complaint on how we have handled your personal information, you can contact the Global Privacy Office and Data Protection Officer at privacy@lilly.com, who will investigate the matter. If you are not satisfied with our response or have any concerns about how your data is being processed, you can register a complaint with a relevant regulatory authority (e.g., a Data Protection Authority (DPA) or Attorney General).

Lilly