

Section 1:  
Patient 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.

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 if you would like to enroll by checking the corresponding checkbox below. By enrolling in the service below, you are agreeing to the Terms of Participation.

1. **Olumiant<sup>®</sup> 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

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

**TERMS OF PARTICIPATION:**

Your healthcare provider has talked with you about using Olumiant<sup>®</sup>, an Eli Lilly and Company medicine. Olumiant Together<sup>™</sup> 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 in Olumiant Together<sup>™</sup>. As part of your participation in Olumiant Together<sup>™</sup>, 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 and 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 Olumiant Together<sup>™</sup> 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 Olumiant Together<sup>™</sup>. These activities include opportunities to share your story and participate in studies about products and services. To cancel your participation in the program, please contact us at 1-844-OLUMIANT (1-844-658-6426) Mon-Fri, 8am -10pm ET.

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

Offer good until 12/31/2025 or for up to 36 months from Patient qualification into the program, whichever comes first. Patients must have coverage for Olumiant through their commercial drug insurance and a prescription consistent with FDA approved product labeling to pay as little as \$5 for a 30-day supply of Olumiant. Offer subject to a monthly cap of wholesale acquisition cost plus usual and customary pharmacy charges and a separate annual cap of \$9,100. Patients must have commercial drug insurance and prescription consistent with FDA-approved product labeling to pay as little as \$25 for a 30-day supply of Olumiant. Participation in the \$25 program requires submission of a prior authorization (PA). If coverage is denied, an appeal must be submitted prior to 5<sup>th</sup> month fill. A new PA and appeal or medical exception (ME) must be submitted every 12 months or as required by Lilly to verify coverage status and potential eligibility for the \$5 program. Offer subject to a monthly cap and a separate annual cap. Monthly and annual caps are set at Lilly's absolute discretion and may be changed by Lilly with or without notice. If a patient's commercial drug insurance plan imposes additional requirements which limits or prevents the patient from receiving coverage, only allows partial coverage, or at Lilly's discretion determines the patient is effectively uninsured because such coverage does not provide a material level of financial assistance for the cost of an Olumiant prescription, or does not apply Olumiant Savings Card Program payments to satisfy the patient's co-payment, deductible, or coinsurance for Olumiant, Lilly has the right to reduce or eliminate the payments provided by the Olumiant Savings Card Program. Participation in the program requires a valid patient HIPAA authorization. Offer void where prohibited by law. Patient is responsible for any applicable taxes, fees, or amounts exceeding monthly or annual caps. **This offer is invalid for Patients without commercial drug insurance or whose prescription claims for Olumiant are eligible to be reimbursed, in whole or in part, by any governmental program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE<sup>®</sup>/CHAMPUS, or any State Patient or Pharmaceutical Assistance Program.** This offer is not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. Available only in the US and Puerto Rico for residents of the US and Puerto Rico who are 18 years of age or older. By accepting this offer, 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 should notify your Insurance Carrier of your redemption of this Card. This offer cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, incentive, or similar offer involving Olumiant. It is prohibited for any person to sell, purchase or trade; or to offer to sell, purchase or trade, or to counterfeit this Card. This offer may be terminated, rescinded, revoked or amended by Lilly USA, LLC at any time without notice. Card activation required. This Card is not health insurance. This Card expires on 12/31/2025. Upon offer expiration, at Lilly's sole discretion you may be eligible to re-enroll by activating a new offer.

**OFFICE:** Complete the entire form and submit pages 1-3 to Olumiant Together™ via fax at 1-844-658-4268 or upload online at <https://patientsupportnow.org> and code: 8446584268. For assistance, call 1-844-OLUMIANT (1-844-658-6426), Monday-Friday 8am – 10pm ET.

Before Olumiant Together™ 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 Olumiant Together™ 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 1-844-OLUMIANT (1-844-658-6426) 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. I understand I am entitled to a copy of this signed Authorization.**



Signature of Patient \_\_\_\_\_ Date Signed (MM/DD/YYYY) \_\_\_\_\_  
 Printed Name of Patient \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_

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



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:  
  L63.0 Alopecia (capitis) totalis  
 L63.1 Alopecia universalis  
 L63.2 Ophiasis  
 L63.8 Other alopecia areata  
 L63.9 Alopecia areata, unspecified

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 \_\_\_\_\_

**Lilly Conducted Benefits Investigation**—Olumiant Together<sup>™</sup> will research the Patient's insurance and in-network Specialty Pharmacy options to help identify the lowest out-of-pocket cost available for Olumiant<sup>®</sup> and will forward the prescription to the Specialty Pharmacy that the Patient selects. An Olumiant Together<sup>™</sup> representative will help triage and troubleshoot access issues on the Patient's behalf. **IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION BELOW.**

**Olumiant<sup>®</sup> Dermatology Prescription — Fill out corresponding prescription below and sign at the bottom of the page**

Olumiant <sup>®</sup> Dosing	Quantity	Days Supply	Refills
<input type="checkbox"/> Olumiant <sup>®</sup> 2 mg tablet, once daily by mouth.	30	30	_____
<input type="checkbox"/> Olumiant <sup>®</sup> 4 mg tablet, once daily by mouth.	30	30	_____
<input type="checkbox"/> Olumiant <sup>®</sup> 1 mg tablet, once daily by mouth for patients with moderate renal impairment or who are taking strong OAT3 inhibitors.	30	30	_____

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 Olumiant<sup>®</sup> 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

## Privacy Notice:

We may use and save your personal information (PI) 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 PI 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.

We may de-identify certain of the information described above. To the extent we maintain and use de-identified information in its de-identified form, and do not re-identify such information except as permitted by law, this de-identified information is not PI and is not subject to this Notice. Where permitted by law, Lilly may also enhance or merge information, including PI, with information obtained from third parties for the same purposes shared above. PI may also be used for profiling for the same purposes shared above. You may object to profiling via automated decision making by contacting us using the information in the "How to Contact Us" section below.

Your information may be combined with other information that you have previously provided or that Lilly has received. We do not sell personal information.

We may transmit personal information about you to other Lilly affiliates worldwide. These affiliates may in turn transmit personal information about you to other Lilly affiliates. Some of Lilly's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Lilly's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about Lilly's privacy practices, including the basis for transfers and safeguards that Lilly has in place for cross-border transfers of personal information, please contact us at [privacy@lilly.com](mailto:privacy@lilly.com) or visit <https://www.lilly.com/privacy>.

We provide reasonable physical, electronic, and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Lilly. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches.

Upon verification, you have the right to request information from us regarding how your personal information is being used and with whom that information is being shared. You also have the right to request to see and get a copy of the personal information that we have about you, request its correction, or request its erasure/deletion.

There may be exceptions that apply to your request.

In limited circumstances, you may have 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 by contacting us using one of the methods listed below.

You may make any of the above requests by contacting us at: The Lilly Answers Center, Lilly USA, LLC, Lilly Corporate Center, Indianapolis, IN 46285 or by calling 1-800-545-5979.

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](mailto: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).

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 in this document.

You will not be discriminated against for exercising any of your rights.

## California Privacy Disclosures

California residents who have an established business relationship with Lilly may have the right to request information regarding Lilly's disclosure of certain PI to Third Parties for their direct marketing purposes. To make a request for such information, you may contact us using the information in this document.

### *Sale and Sharing of Personal Information*

Lilly does not sell PI about California consumers that are protected under the California Consumer Privacy Act of 2018 ("CCPA") or California Privacy Rights Act ("CPRA") to third parties or share such PI with third parties for targeted or cross-context behavioral advertising, as those terms are defined by applicable law. When Lilly permits third parties to collect PI through our websites or discloses PI to third parties, Lilly is doing so pursuant to various exceptions to the opt-out rights provided for under California law. For example, Lilly permits third parties acting on its behalf to process PI for the business purposes described in this Notice including advertising and marketing services (excluding cross-context behavioral advertising). In addition, Lilly may permit third-party advertising solutions to process PI when you direct us to do so by agreeing to the use of such technologies to personalize Lilly's content and ads. Consistent with the above, Lilly does not sell or share for cross-context behavioral advertising PI relating to consumers who it knows are under 16 years of age.

### *Sensitive Personal Information*

Lilly does not use or disclose your sensitive PI except for limited purposes that are authorized by law. For example, Lilly may collect information about your health or medical diagnosis to provide you specific functionality or products or services that you have requested. California law does not afford you rights to limit the use or disclosure of sensitive PI for these purposes, although we may nonetheless ask for your consent or provide you choices about how we use this information depending on the relevant context.