FORTEO CONNECT PATIENT SUPPORT PROGRAM

Telephone: 1-866-4-FORTEO (1-866-436-7836) **Fax:** 1-866-436-7830
Address: PO Box 4668, Trenton, NJ 08650-9108

PP-TE-US-0753 02/2017. ©Lilly USA, LLC 2017. All rights reserved. FORTEO is a registered trademark of Eli Lilly and Company.

PLEASE SIGN AND FAX COMPLETED FORM **(FRONT AND BACK)** TO 1-866-436-7830

Patient Information (all fields required)

Patient's Name: Last: ____________ First: ____________ MI: ___ Date of Birth (MM/DD/YYYY): ____________

Gender: ❑ Male ❑ Female Language: ❑ English ❑ Spanish ❑ Other ____________

Address: ____________ City: ____________ State: _______ ZIP Code: ____________

Phone #:* ____________

*If I provide my cell phone number and submit this form, I consent to receive automated calls and texts about FORTEO Connect at this number. I understand that I am not required to provide my cell phone number to participate in the program, but if I do not then I will not be able to receive program communications. By signing, I agree and certify that I am eighteen (18) years of age. **I have read and agree to the HIPAA Authorization on the back of this form.**

Patient Signature: X ____________ **Date:** ____________

OR

Personal Representative Signature†: X ____________ **Printed Name:** ____________ **Date:** ____________

†A personal representative is an individual authorized to act on behalf of the patient in accordance with state law.

Prescription Insurance Information (for Insurance Investigation only)

Please attach copy of front and back of patient's primary insurance card/prescription benefits card, or complete the following:

Insurance/Prescription Benefits: ____________ Cardholder Name: ____________

ID #: ____________ Group #: ____________ Phone #: ____________

Employer: ____________ ❑ No insurance coverage

Support Services Requested for This Patient

❑ Injection Training ❑ Insurance Investigation ❑ Field Reimbursement Support

Our Reimbursement Support Specialist can help your office answer questions related to the insurance investigation and approval processes.

Prescriber Information (all fields required)

Prescriber's Name: Last: ____________ First: ____________ NPI #: ____________

Address: ____________ City: ____________ State: _______ ZIP Code: ____________

Office Contact: ____________ Phone #: ____________ Fax #: ____________

By signing below, I certify that the therapy is medically necessary and that this information is accurate to the best of my knowledge. I also represent that I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient, to Eli Lilly and Company and Lilly USA, LLC and its agents for the purpose of assessing whether the patient qualifies for any reimbursement benefits through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Lilly so that Lilly may contact the patient to further enable these services. Additionally, I appoint Lilly USA, LLC, acting on my behalf, to convey this prescription to the dispensing pharmacy.

Prescriber's Signature: X ____________ **X** ____________ **Date (MM/DD/YYYY):** ____________

Dispense as written **May substitute**

STAMP SIGNATURES NOT ACCEPTED

Clinical Information (for Insurance Investigation only)

Patient determined to be at high risk for fracture due to:

❑ postmenopausal osteoporosis ❑ primary or hypogonadal osteoporosis ❑ glucocorticoid-induced osteoporosis

Additional information or forms may be needed and a FORTEO Connect Support Specialist will contact your office with any additional requirements.

Prescription Information (for Insurance Investigation only)

℞ **Medication: FORTEO® (teriparatide [rDNA origin] injection)**, 2.4-mL delivery device, NDC 0002-8400-01

Directions: Inject 20 mcg subcutaneously daily

Quantity: ❑ Up to an 84-day supply Refills: ❑ 3 ❑ 5 ❑ 11 ❑ Other

Please note: renewal of initial prescription is required after 1 year.

Include Needle Gauge (quantity 1 box)

____ gauge

(BD pen needles are recommended)

Additional Instructions: ____________

Lilly

FORTEO CONNECT PATIENT SUPPORT PROGRAM

Telephone: 1-866-4-FORTEO (1-866-436-7836) **Fax:** 1-866-436-7830
Address: PO Box 4668, Trenton, NJ 08650-9108

PP-TE-US-0753 02/2017. ©Lilly USA, LLC 2017. All rights reserved. FORTEO is a registered trademark of Eli Lilly and Company.

Patient HIPAA Authorization

This program is available free of charge from Eli Lilly and Company (Lilly USA, LLC). If you don't have a health care plan, or your health care plan won't pay for your prescribed Lilly treatment, and you meet certain financial and medical standards, we will work with you and your physician(s) to find possible sources of reimbursement.

Before we can begin the process of assisting you, we need to collect, use, and disclose your Protected Health Information. Protected Health Information includes any information related to your health care insurance or plan benefits, including coverage limits; all health records related to your treatment, including any medical information we may receive and any information that has a bearing on your health or whether you're staying on your medicine or treatment. Although we are not looking for Protected Health Information that is unrelated to your Lilly treatment, it may be part of the health records sent to us.

When signed by you, this form permits your Protected Health Information to be released to us by your doctors, your health care plan or insurance company, your pharmacies, or others who might hold your Protected Health Information. Once you sign this form and it is sent back to us, we can use the released health information to provide the support services described on the previous page.

You do not have to sign this consent, but we cannot provide our services without it. You might need to pay for your Lilly product on your own, whether you sign this form or not.

PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS FORM. YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.

I understand that by signing this form, I authorize my doctors, my health care plan or insurance company, my pharmacies, or others who might hold my Protected Health Information to release it to Lilly USA, LLC employees, as well as to its vendors and business partners who are performing services related to this program.

My Protected Health Information may be used to help determine my health care plan coverage for Lilly treatments prescribed by my doctor and other procedures as part of my therapy on Lilly treatments; identify or track my use of prescribed Lilly treatments; contact me to collect any additional information needed to provide these services to me; or measure and track the quality of services performed by program staff.

I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration (payment) from Lilly in exchange for disclosing my Protected Health Information and/or for using my information to provide me with therapy support services such as to contact me with communications about Lilly products.

I understand that once my doctors, health care plan, pharmacies, or others who have my Protected Health Information release it, my information may no longer be covered by Federal Privacy Law (for example, HIPAA).

This authorization allows those who rely on it to release my Protected Health Information for 1 year from the date I have signed it. I can withdraw it at any time by sending a written notice to the address listed above. My withdrawal goes into effect once it is received by the program.

PLEASE FAX COMPLETED FORM **(FRONT AND BACK)** TO 1-866-436-7830

Lilly