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

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 #:* _____ E-mail: _____

*By providing my cell phone number and signing this form, I agree to receive automated (and/or prerecorded) calls and texts about FORTEO Connect. I understand that no purchase is necessary to receive these calls or texts. 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 at least 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.

Support Services Requested for This Patient

❑ **Information and Injection Training:** Training and education from a FORTEO Connect Nurse Educator

❑ **Insurance Investigation (includes Field Reimbursement Support):**

-Help with insurance investigation and pharmacy triage to patient's preferred pharmacy

-Medication cost options and determine eligibility for savings program (including co-pay card)

❑ **Field Reimbursement Support:** The Field Reimbursement Manager is an experienced access professional who can help navigate the complex access and reimbursement environment

Specialty Pharmacy where prescription was sent: _____

Clinical Information (mandatory for Insurance Investigation and Field Reimbursement Support Fulfillment)

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

❑ postmenopausal osteoporosis (female only) ❑ 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 Insurance Information (for Insurance Investigation)

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

Prescriber Information (all fields required)

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

Address: _____ City: _____ State: _____ ZIP Code: _____

Office Contact: _____ Phone #: _____ Fax #: _____

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: ❑ 28-day supply OR ❑ up to 84-day supply

Refills: ❑ 3 ❑ 5 ❑ 11 ❑ Other

Include Needle Gauge (quantity 1 box)

____ gauge

(BD pen needles are recommended)

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

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 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 purpose of conveying this prescription to the dispensing pharmacy.

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

Dispense as written **May substitute**

STAMP SIGNATURES NOT ACCEPTED

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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 Eli Lilly and Company and Lilly USA, LLC, and its affiliates, agents, representatives, business partners, and service providers (together "Lilly") 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 Lilly cannot provide the services described on this form 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, who is 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.

I understand that by signing the front of this form, I am providing legal authorization for Lilly to use and share, and for my Healthcare Providers to disclose, my personal information including my Protected Health Information for the purposes described above.

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