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

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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

Lilly Support Services™

PRESCRIBER ENROLLMENT SECTION

Kisunla™ (donanemab-azbt)
injection for IV infusion

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Section 5: Prescriber Information

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

PTAN # _____ **Tax ID #** _____ **Phone** _____ **Fax** _____

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

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

Office Contact Email _____

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

Section 6: Service Selection

Benefits Investigation

Who is conducting the Benefits Investigation? Please select the appropriate option from the following:

☐ **HCP or Infusion Center Conducted Benefits Investigation -** The Prescriber's office, referred Infusion Center, or another party (e.g., Specialty Pharmacy) will research the Patient's insurance to help identify the lowest out-of-pocket cost available for Kisunla™.
(Proceed to Care Coordination and Infusion Center Locator Support service requests, if desired)

OR

☐ **Lilly Conducted Benefits Investigation -** Lilly Support Services™ will research the Patient's insurance to help identify the lowest out-of pocket cost available for Kisunla™, which may include Patient eligibility for a Savings Card. A Lilly Support Services™ representative will help troubleshoot access issues on the Patient's behalf and determine eligibility for a program Savings Card, if applicable.
(Please make additional Benefits Investigation selections, if desired)

As part of the Lilly Conducted Benefits Investigation, Lilly Support Services™ can also research estimated costs associated with the treatment of Kisunla™. Please select any additional costs that you would like Lilly Support Services™ to investigate:

- ☐ Infusion administration estimate
- ☐ MRI estimate (CPT# 70551: MRI, brain, including brain stem, without dye)

If coverage attempts (e.g., Prior Authorization, Pre-Certification, etc.) are required for Kisunla™, the party responsible for completing the coverage attempt(s) will be:

- ☐ Prescribing HCP
- ☐ Referred Infusion Center

☐ **Care Coordination** – This service on behalf of your Patients helps facilitate confirmation of requirements across their Kisunla™ treatment team, such as MRIs or other medical documentation. Reminders will be provided to HCPs when additional documentation or tests are needed for Patients on Kisunla™. Lilly Support Services™ helps your Patients navigate the logistics associated with treatment to support a smoother experience while on Kisunla™. Lilly Support Services™ for Kisunla™ recommends that the Lilly Conducted Benefits Investigation service is also selected so that additional information can be gathered that will enable Care Coordination follow ups at the appropriate time. In the absence of a Benefits Investigation, Lilly Support Services™ for Kisunla™ will conduct Care Coordination following the Medicare Patient process unless otherwise marked on the enrollment.

Infusion Center Locator Support (must select one choice below) – Lilly Support Services™ can help your Patient locate a convenient infusion site to receive their Kisunla™ treatment. Additionally, if Lilly Conducted Benefits Investigation is selected, Lilly Support Services™ will also attempt to gather the network status of identified infusion sites. If the Prescriber is not infusing in the office and Sections 7, 8, 9, and 10 are completed, Lilly Support Services™ will send the prescription and infusion order to the selected infusion site.

☐ Prescriber is requesting support in locating an Infusion Center

OR

☐ Prescriber will infuse in office (information listed in Section 5 above)
Please provide the Practice Name _____
and the Organizational NPI # _____ for the In-Office Infusion Center
(IF SELECTED, SKIP INFUSION CENTER LOCATION AND SECTIONS 8 AND 9)

OR

☐ Prescriber is referring to the following site (**IF SELECTED, MUST FILL OUT INFUSION CENTER LOCATION SECTION BELOW**):

Infusion Center Location – Must be completed if Prescriber selected a Referral Infusion Site

Infusion Center Type:

☐ **Non-Prescribing MD's Office** ☐ **Hospital Outpatient** ☐ **Stand-Alone Infusion Center** ☐ **Other** _____

Office/Hospital/Other Name _____

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

Office Contact _____ **Phone** _____ **Fax** _____

NPI # _____ **PTAN #** _____

Lilly Support Services™

PRESCRIPTION AND INFUSION ORDER FORM

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Section 7: Patient Information and Diagnosis

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

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

Allergies _____

Current Medications _____

Other Medical Conditions or Additional Comments: _____

Medical History Related to IV Insertion (e.g. lymph nodes or mastectomy): _____

Diagnosis

- ☐ **G30.0 Alzheimer's disease with early onset**
- ☐ **G30.1 Alzheimer's disease with late onset**
- ☐ **G30.8 Other Alzheimer's disease**
- ☐ **G30.9 Alzheimer's disease, unspecified**
- ☐ **G31.84 Mild cognitive impairment, so stated**

Note: If Prescriber is infusing In-Office, Sections 8 and 9 are not required.

Section 8: Prescription

The Prescriber is requesting the following regarding the prescription and infusion order:

☐ Lilly Support Services™ will triage the prescription and infusion order on the Patient's behalf to the identified Infusion Center. **(IF SELECTED, PLEASE COMPLETE SECTIONS 8 AND 9)**

OR

☐ Lilly Support Services™ will **NOT** triage the prescription and infusion order on the Patient's behalf to the identified Infusion Center. **(IF SELECTED, PLEASE PROCEED to Section 10)**

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

Kisunla™ Dosing	Quantity	Days Supply	Refills
☐ Starting Dose: Infuse 700 mg intravenously over approximately 30 minutes once every 4 weeks for Infusions 1, 2, and 3	2 vials	28	2
☐ Dose Post Infusion 3: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter	4 vials	28	_____

You must select at least one Dosing option. You may select both.

Section 9: Infusion Order Information Protocol

Administration Protocol:

IV Infusion (every 4 weeks)	Kisunla™ Dosage (administered over approximately 30 min)
Infusions 1, 2, and 3	700 mg
Infusions 4+	1400 mg

- Observe the Patient post-infusion for a minimum of 30 minutes to evaluate for infusion reactions and hypersensitivity reactions
- At first observation of any signs or symptoms consistent with a hypersensitivity or infusion-type reaction, stop infusion and treat per orders/protocol, as clinically indicated
- Schedule treatments every 4 weeks. Order valid for one year unless otherwise indicated:
  - ☐ Order expires on: _____
  - ☐ Order expires after _____ treatments

Post-Infusion:

- Send treatment notes to Prescriber via fax to: _____ or via email to: _____

Section 10: Prescriber Signature

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. I understand that by signing this form, I am requesting support from Eli Lilly and Company for a Patient receiving Kisunla™ pursuant to an FDA approved indication and attest that the Patient is eligible to undergo MRI per the Kisunla label.

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.

_____ _____

Prescriber Signature **Date Signed (MM/DD/YYYY)**

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

Lilly

Lilly Support Services™

PUBLISHED 01/2025

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