LILLY CANADA
Patient Assistance Program Application
Tel: 1-877-545-5922 Fax: 1-877-691-8866
Email: info@LPAP-PAPL.ca

The Lilly Canada Patient Assistance Program is designed to help patients who are permanent residents of Canada that need but cannot afford Lilly medicines. It provides medication to eligible patients at no cost for a pre-determined period of time. Please note that the program has a finite amount of available space for patients per product for its entire duration. To ensure that patients across the country have a reasonable chance of accessing the program, we support up to a maximum of 6 patients per Health Care Professional who has prescribing authority, assuming that the national program maximum has not been reached for that year. Diabetic products can be prescribed by physicians, pharmacists, nurse practitioners, nurses, dietitians, and certified diabetes educators.

HOW DO I APPLY? (USE THIS CHECKLIST)

To ensure your application is not delayed:

- Ensure the medication is being prescribed in accordance with the Product Monograph.
- Complete all the sections on the Patient Assistance Application Form.
- Sign and date the Prescriber Certification section and confirm that the patient's verbal authorization has been obtained.
- Fax or email the completed application to the fax number or email address listed at the top of this page.

WHAT HAPPENS NEXT?

All applications will be reviewed to determine eligibility for the program.

- Enrollment will be confirmed within 2 to 3 business days of receipt of the completed application form.
- If the patient is eligible, he/she will be enrolled for 6 months after which time the prescriber must re-apply (by sending a new application or by responding to the renewal form proactively sent by the program).
- The patient will pick up the medication from the Prescriber's office.
- If the patient is not eligible, the prescriber will receive a letter stating the patient was denied enrollment.

MEDICINES AVAILABLE TO ELIGIBLE PATIENTS THROUGH THE LILLY CANADA PATIENT ASSISTANCE PROGRAM
(Note: The availability of products is subject to change at any time)

PRODUCT	INDICATION	MINIMUM AGE (YEARS)	MAXIMUM ELIGIBLE DAILY DOSE	STRENGTH/FORMAT AVAILABLE
BAQSIMI® (glucagon nasal powder)	Treatment of severe hypoglycemic reactions which may occur in the management of insulin treated patients with diabetes mellitus, when impaired consciousness precludes oral carbohydrates.	4 +	1 device	3mg/device
Humalog®100 units/mL, Humalog® Mix 25®*, Humalog® Mix 50®* (insulin lispro for injection)	Treatment of diabetes	Doctor's discretion	N/A	Cartridge KwikPen® Vial **Vial format not available*
Humalog® 200 units/mL (insulin lispro for injection)	Reserved for the treatment of patients with diabetes requiring daily doses of more than 20 units of fast-acting insulin.	Doctor's discretion	N/A	KwikPen®
Humalog® Junior 100 units/mL (insulin lispro for injection)	Treatment of diabetes	Doctor's discretion	N/A	KwikPen®
Humulin® N® (insulin human for injection)	Treatment of diabetes	Doctor's discretion	N/A	Cartridge, KwikPen®, Vial
Humulin® R® (insulin human for injection)	Treatment of diabetes	Doctor's discretion	N/A	
Humulin® 30 / 70, (insulin human for injection)	Treatment of diabetes	Doctor's discretion	N/A	Cartridge, Vial

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PATIENT INFORMATION (all fields are required)

Patient ID (For Program Use Only): _____

Patient name*: (Last)_____(First)_____Date of birth (YYYY/MM/DD): _____

Gender*: ☐ M ☐ F Is this patient a Permanent Canadian Resident? ☐ Y ☐ N Patient Province of Residence:_____

PRESCRIBER INFORMATION (all fields are required)

Prescriber's name*:_____Title:_____License #:_____

Office/clinic name:_____Office/Clinic Email:_____

Office/Clinic Mailing address:_____City: _____
(include "Attn to" if applicable)

Province/territory:_____Postal code:_____Phone: (____) ____ - ____ Fax#: (____) ____ - ____

Preferred Office Contact:_____Preferred Communication Language: ☐ EN ☐ FR
***Please ensure that the prescriber (physician/HCP) name MATCHES the signature provided below.**

All shipments will be sent to the requesting HCP's practice location indicated above. Delivering to an alternate delivery location cannot be accommodated by Lilly PAP.

PRESCRIBING INFORMATION (all fields are required)

Drug Name:_____Strength:_____Indication:_____

Drug Form: ☐ Vial ☐ Cartridge ☐ KwikPen ☐ Tablet ☐ Other (Specify):_____Quantity Req. for 6 months:___

SIG (Daily Dosage): _____
(If prescribing insulin indicate max number of units a day)
Consider the condition of your patient and use your medical judgment to determine the appropriate amount of medication to provide at any given time.

PATIENT COVERAGE AND INSURANCE INFORMATION (all fields are required)

1. Does the patient have prescription drug coverage for the requested medication through a private payer? ☐ Y ☐ N
   If yes, provide the reason for compassionate application: _____
2. Is the requested medication a benefit of the patient's provincial or territorial drug benefit program? ☐ Y ☐ N
3. Has the patient applied for provincial or territorial coverage? ☐ Y ☐ N
   If **no**, provide the reason the patient has not applied: _____
   If **yes**, provide the reason for compassionate application despite available provincial or territorial drug coverage availability:
   _____

PRESCRIBER'S CERTIFICATION AND AGREEMENT TO PARTICIPATE IN PROGRAM

I certify that the medication being requested is medically necessary for this patient and that I have prescribed (or in the case of insulin, requested) this Eli Lilly Canada Inc. ("Lilly") medication for this patient in accordance with the product monograph. I confirm that, to the best of my knowledge, this patient does not have prescription drug insurance coverage and that she/he is in no position to afford the medication. I confirm that I have explained to my patient that this program is temporary, that re-application at designated intervals will be required, and that Lilly is under no obligation whatsoever to provide my patient with any assistance at this time or in the future. I agree to the collection, use and disclosure of the information on this form by Lilly and its third-party service providers (who have agreed to abide by Lilly's privacy policies), in accordance with Lilly's Privacy Statement and for purposes related to the administration and monitoring of the program, including assessing my patient's eligibility for participation in the program. I certify that my patient has consented to the collection, use and disclosure of the information on this form by Lilly and its third-party service providers for these purposes. I have informed my patient of his/her right to: (i) access or correct personal information held by Lilly and its third-party service providers; (ii) request a copy of Lilly's Privacy Statement; and (iii) revoke his/her consent. I have advised my patient that if consent is revoked, she/he will no longer be eligible to participate in the program. Lilly's Privacy Statement is available upon request by contacting: c/o Chief Privacy Officer, Eli Lilly Canada Inc., P.O. Box 73, Exchange Tower, 130 King Street West, Suite 900, Toronto, Ontario M5X 1B1. For further information please call 1-888-545-5972.

Verbal authorization from patient: ☐ Yes ☐ No

Prescriber signature:_____**Date**:_____
Original signature only; no photocopies or stamps