Lilly Oncology Support Center

PATIENT ENROLLMENT SECTION
Retevmo® (selpercatinib)

PUBLISHED 03/2024

OFFICE: Complete the entire form and submit pages 1-4 to the Lilly Oncology Support Center™ via fax at 1-877-427-4030. For assistance, call 1-866-472-8663, Monday-Friday 8am – 10pm ET.

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** _____

☐ No ☐ Yes **The primary insurance listed above is a commercial coverage plan and is active.**

☐ No ☐ Yes **Do you use government insurance to fill your prescriptions? Examples include Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS**

Section 3: Service Selection

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using Retevmo®, an Eli Lilly and Company medicine. The Lilly Oncology Support Center™ 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 the Lilly Oncology Support Center™. As part of your participation in the Lilly Oncology Support Center™, 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 Oncology Support Center™ 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 the Lilly Oncology Support Center™. 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 1-866-472-8663 Mon-Fri, 8am -10pm ET. For information about Lilly's privacy practices, please see our Privacy Statement at https://privacynotice.lilly.com.

Please continue to the next page.

Lilly Oncology Support Center

PATIENT HIPAA AUTHORIZATION

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Before the Lilly Oncology Support Center™ 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 the Lilly Oncology Support Center™ 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 501847, Rancho Bernardo, CA 92150, 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 1-866-472-8663 or by writing us at PO Box 501847, Rancho Bernardo, CA 92150**
- **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. By signing this Authorization, I represent that I am the Authorized Representative for the Pediatric Patient. 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 Oncology Support Center

PRESCRIBER ENROLLMENT SECTION
Retevmo® (selpercatinib)

PUBLISHED 03/2024

OFFICE: Complete the entire form and submit pages 1-4 to the Lilly Oncology Support Center™ via fax at 1-877-427-4030. For assistance, call 1-866-472-8663, Monday-Friday 8am – 10pm ET.

Section 4: Prescriber information

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

Practice Name _____ **Phone** _____ **Fax** _____

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

Group Tax ID _____ **Office Contact Name** _____ **Office Contact Phone** _____

Office Contact Email _____ **Secondary Office Contact** _____

Section 5: Diagnosis

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

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

Diagnosis:

- ☐ Adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with a rearranged during transfection (RET) gene fusion, as detected by an FDA-approved test
- ☐ Adult and pediatric patients 12 years of age and older with advanced or metastatic medullary thyroid cancer (MTC) with a RET mutation, as detected by an FDA-approved test, who require systemic therapy[1]
- ☐ Adult and pediatric patients 12 years of age and older with advanced or metastatic thyroid cancer with a RET gene fusion, as detected by an FDA-approved test, who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate)[1]
- ☐ Adult patients with locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options[1]
- ☐ Diagnosis supported by CMS-recognized compendia and not unsupported in any CMS approved compendia

[1]This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Section 6: HCP Service Selection & Prescription

Benefits Investigation Support (select one choice)

- ☐ **Lilly Conducted Benefits Investigation**—The Lilly Oncology Support Center™ will research the Patient's insurance and in-network Specialty Pharmacy options to help identify the lowest out-of-pocket cost available for Retevmo® and will forward the prescription to the Specialty Pharmacy that the Patient selects. A Lilly Oncology Support Center™ representative will help triage and troubleshoot access issues on the Patient's behalf. **IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION BELOW.**

OR

- ☐ **Specialty Pharmacy Conducted Benefits Investigation**—Specialty Pharmacy where prescription was sent _____
  Specialty Pharmacy Phone Number _____

☐ **Retevmo Interim Access Program™ Support** – The Retevmo Interim Access Program™ provides a 15-day supply of Retevmo® at no charge for eligible, insured Patients who are new to Retevmo® and experiencing a minimum 5-business-day delay in insurance coverage. Not available to Patients whose insurers have made a final determination to deny coverage for Retevmo®. If there is a persistent coverage delay, the Patient, under appropriate circumstances, may be eligible for up to three additional 15-day supplies of Retevmo®. Free product for the Retevmo Interim Access Program™ is only available through a Non-Commercial Specialty Pharmacy. No purchase contingency or other obligation accompanies program participation. **The Retevmo Interim Access Program™ does not guarantee coverage.** Lilly reserves the right to change or end the program at any time. Additional Terms and Conditions apply - see page 4. **IF CHECKED, MUST READ ELIGIBILITY REQUIREMENTS ON PAGE 4 AND SIGN.**

Retevmo® Prescription - Fill out corresponding prescription below and sign at the bottom of page

You must select the appropriate Dosing

Dosing	Quantity to be Dispensed	Refills
☐ 160mg (2 x 80mg capsules) orally twice daily Recommended for patients with body weight 50kg or greater	120 Tablets (30 day supply)	**Refills** _____
☐ 120mg (3 x 40mg capsules) orally twice daily Recommended for patients with body weight less than 50kg	180 Tablets (30 day supply)	
☐ 80mg (80mg capsule) orally twice daily	60 Tablets (30 day supply)	
☐ 40mg (40mg capsule) orally twice daily	60 Tablets (30 day supply)	
☐ 40mg (40mg capsule) orally once daily	30 Tablets (30 day supply)	

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 Retevmo® pursuant to an FDA approved indication or an indication medically supported by CMS-recognized compendia and the use is not listed as unsupported, not indicated, or not recommended in any CMS-recognized compendia. **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.

☐ **I confirm the Patient tested positive for a *RET* Alteration**

_____ _____ _____

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

RETEVMO INTERIM ACCESS PROGRAM™ REQUIREMENTS

PUBLISHED 03/2024

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Retevmo Interim Access Program™ Requirements

To be eligible for the Retevmo Interim Access Program™, a Patient must: 1) be a new Retevmo® Patient who has tested positive for a *RET* alteration; 2) be experiencing a minimum 5-business-day delay in insurance coverage determination; 3) be prescribed Retevmo® for an FDA-approved indication or an indication medically supported by CMS-recognized compendia; 4) be enrolled in the Lilly Oncology Support Center™; 5) be 18 years of age or older or an Authorized Representative of a Patient under age 18; and 6) be a resident of the United States or Puerto Rico.

Please note: This program is provided by Sonexus Non-Commercial Specialty Pharmacy (NCSP) rather than your in-office dispensary or any other Specialty Pharmacy your Patient may later use. We will contact your office when the Patient has received his/her dose.

Terms and Conditions:

The Retevmo Interim Access Program (or "Program") provides a 15-day supply of Retevmo at no charge for eligible, insured patients who are:
1) prescribed Retevmo for the first time after testing positive for a *RET* alteration,
2) experiencing a minimum 5-business-day delay in insurance coverage determination,
3) prescribed Retevmo for an FDA-approved indication or an indication medically supported by CMS-recognized compendia, and
4) enrolled in the Lilly Oncology Support Center,
5) residents of the United States or Puerto Rico.

May not be combined with any other offer. Not available to patients whose insurers have made a final determination to deny the patient coverage for Retevmo. If a denial is received after the initial 5 business days have passed and appeal rights are being pursued, or if there is a persistent coverage delay, the patient, under appropriate circumstances, may be eligible for up to 3 additional 15-day supplies of Retevmo. Product provided through the Program is only available through the Program non-commercial specialty pharmacy. Product is provided free of charge and may not be sold, bartered, or returned for credit. Reimbursement cannot be sought from any third party for product provided under the program. Patients enrolled in Medicare Part D are prohibited from counting any portion of the cost of the product provided under the Program towards true out-of-pocket ("TrOOP") costs for prescription drug calculations. No purchase contingency or other obligation accompanies program participation. This Program is not health insurance and does not guarantee coverage. Lilly reserves the right to change or end the program at any time. Benefits under the program are not transferable.

☐ **I certify and agree to the above Retevmo Interim Access Program™ Terms and Conditions. By signing this Authorization, I represent that I am the Authorized Representative for the Pediatric Patient 12 years of age or older.**

Signature of Patient or Authorized Representative _____ **Date Signed (MM/DD/YYYY)** _____

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

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

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

Retevmo® Prescription - Fill out corresponding prescription below and sign at the bottom of page

Primary Diagnosis:	Dosing:	Quantity to be Dispensed
☐ Adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with a *rearranged during transfection (RET)* gene fusion, as detected by an FDA-approved test	☐ 160mg (2 x 80mg capsules) orally twice daily Recommended for patients with body weight 50kg or greater	60 Tablets (15 day supply)
☐ Adult and pediatric patients 12 years of age and older with advanced or metastatic medullary thyroid cancer (MTC) with a *RET* mutation, as detected by an FDA-approved test, who require systemic therapy[1]	☐ 120mg (3 x 40mg capsules) orally twice daily Recommended for patients with body weight less than 50kg	90 Tablets (15 day supply)
☐ Adult and pediatric patients 12 years of age and older with advanced or metastatic thyroid cancer with a *RET* gene fusion, as detected by an FDA-approved test, who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate)[1]	☐ 80mg (80mg capsule) orally twice daily	30 Tablets (15 day supply)
☐ Adult patients with locally advanced or metastatic solid tumors with a *RET* gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options[1]	☐ 40mg (40mg capsule) orally twice daily	30 Tablets (15 day supply)
☐ Diagnosis supported by CMS-recognized compendia and not unsupported in any CMS approved compendia	☐ 40mg (40mg capsule) orally once daily	15 Tablets (15 day supply)

You must select a Diagnosis and Dosing

[1]This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Prescriber: I certify that I understand and agree: 1) To the terms and conditions of the Retevmo Interim Access Program™; 2) I am licensed to prescribe the medication identified in this form, and that the prescription complies with my state-specific prescribing requirements; 3) In my medical judgment, Retevmo® is clinically appropriate for the Patient named above and its use is consistent with the FDA-approved indication or an indication medically supported by CMS-recognized compendia and not unsupported in any CMS approved compendia; 4) This supply of Retevmo® is specifically for the Patient named above; and 5) I will not seek reimbursement from any third party for the support Lilly provides. **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.

☐ **I confirm the Patient tested positive for a *RET* Alteration**

Dispense as written _____ **May substitute/brand exchange permitted** _____ **Date Signed (MM/DD/YYYY)** _____

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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).