Lilly Oncology
Support Center

Retevmo® (selpercatinib) Enrollment Form

UPDATED 09/2022

Please complete and fax this form to **1-877-427-4030**

If you have any questions, please call the Lilly Oncology Support Center™ at 1-866-472-8663, Monday-Friday 8am-10pm ET

By enrolling in the Retevmo Savings and Support Program™, Patients may receive various forms of support and information to help access Retevmo®, which may include the following:

- Benefits Investigation Support
- Copay Savings and Other Financial Support
- Field Reimbursement Support
- Interim Access Support
- Ongoing Support

In order to process the requested services, we require 2 Patient signatures and 1 Prescriber signature. If Interim Access Support is being requested, we will require another Patient signature and another Prescriber signature accepting the Interim Access Program™ Terms and Conditions. Not signing this form will result in an incomplete submission and a delay in requested services.

Patient Enrollment Checklist:

Page 2

- ☐ Complete all sections in the Patient Enrollment section
- ☐ Document insurance information or provide copies of your insurance and prescription card(s)
- ☐ Select optional Lilly Oncology Support Center™ services that you would like to receive

➔ **Be sure to sign and date where "Signature of Patient or Authorized Representative" is located**

Page 3

➔ **Read and sign Patient HIPAA Authorization**

Page 5 (only if requesting Retevmo Interim Access Program™ Support)

➔ **Be sure to sign and date where "Signature of Patient or Authorized Representative" is located**

Pages 6-8

- ☐ Read and acknowledge the Consent, Terms and Conditions, and Privacy Notice on remaining pages

Prescriber Enrollment Checklist:

Page 4

- ☐ Complete all sections in the Prescriber Enrollment section
- ☐ Complete the prescription section, including: primary diagnosis, dosing, and number of refills
- ☐ If Interim Access Support is requested, please fill out the Interim Access Support Prescription Section on Page 5 and sign
- ☐ Select appropriate Benefits Investigation Support Option
  - *If selecting Specialty Pharmacy Conducted Benefits Investigation, indicate which Specialty Pharmacy the prescription should be sent to*

➔ **Confirm the Patient tested positive for a *RET* Alteration**

➔ **Manually sign and date the form**

Page 5 (only if requesting Retevmo Interim Access Program™ Support)

- ☐ Complete the prescription section, including: primary diagnosis and dosing

➔ **Confirm the Patient tested positive for a *RET* Alteration**

➔ **Manually sign and date the form**

Complete and fax this form to **1-877-427-4030**

Lilly Oncology
Support Center

PATIENT ENROLLMENT SECTION
Retevmo® (selpercatinib)

UPDATED 09/2022

OFFICE: Please fax to 1-877-427-4030

Patient: **Fill out only the Patient section and sign where indicated**

Authorized Representative: **Fill out both the Patient section and the Authorized Representative section and sign where indicated**

Patient

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

Address _____ **City** _____ **State** _____ **ZIP Code** _____

US or Puerto Rico Resident ☐ Yes ☐ No **Gender** ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone* _____ **Email** _____

*By providing my telephone number and signing this form, 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 purchase. Message and data rates may apply.

The Authorized Representative should fill out the section below and sign on behalf of the Pediatric Patient 12 years of age or older

Authorized Representative

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

Relationship to Patient _____

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

US or Puerto Rico Resident ☐ Yes ☐ No **Gender** ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Phone* _____ **Email** _____

*By providing my telephone number and signing this form, 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 purchase. Message and data rates may apply.

By signing this form as the Authorized Representative, 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

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**

Please select which options you would like to enroll in by checking the corresponding checkboxes below.

☐ I would like a **Retevmo® Savings Card** and agree to the Saving Card Terms and Conditions on page 6

SAVINGS CARD ELIGIBILITY (must confirm the below statements in order to be eligible)

☐ I confirm that I am a resident of the United States or Puerto Rico who is 18 years of age or older

☐ I confirm that I am NOT enrolled in a government-funded prescription program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state or pharmaceutical assistance program

☐ I would like **Retevmo® Ongoing Support** and agree to the Optional Retevmo® Ongoing Support Enrollment Consent on page 7

I understand I am enrolling in the Lilly Oncology Support Center™ to help facilitate access to my prescribed medication. By checking the corresponding optional boxes above, I consent to my enrollment in the additional Lilly Oncology Support Center™ services as described in the Consent on page 7. To cancel your participation in the program, please contact us at 1-866-472-8663.

Lilly

Lilly Oncology
Support Center

PATIENT HIPAA AUTHORIZATION

OFFICE: Please fax to 1-877-427-4030

UPDATED 09/2022

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 12307, La Jolla, CA 92039, 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 12307, La Jolla, CA 92039**
- **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**

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 12 years of age or older. I understand I am entitled to a copy of this signed Authorization.

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

Printed Name of Patient/Authorized Representative _____ **Date of Birth (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)
UPDATED 09/2022

OFFICE: Please fax to 1-877-427-4030

Prescriber

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** _____

Patient

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

You must select a Diagnosis and Dosing

Primary Diagnosis:	Dosing	Quantity to be Dispensed	Refills
☐ 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	120 Tablets (30 day supply)	**Refills** _____
☐ 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	180 Tablets (30 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	60 Tablets (30 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	60 Tablets (30 day supply)	
☐ Diagnosis supported by CMS recognized compendia and not unsupported in any CMS approved compendia	☐ 40mg (40mg capsule) orally once daily	30 Tablets (30 day supply)	

[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).

Benefits Investigation Support (select one choice)

OR

☐ **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 ABOVE.**

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

☐ **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. **IF CHECKED, MUST READ ELIGIBILITY REQUIREMENTS ON PAGE 5 AND SIGN.**

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. **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

Lilly Oncology Support Center

RETEVMO INTERIM ACCESS PROGRAM™ REQUIREMENTS

UPDATED 09/2022

OFFICE: Please fax to 1-877-427-4030

Retevmo Interim Access Program™ Requirements

To be eligible for the Retevmo Interim Access Program™, a Patient must: 1) be a new Retevmo® Patient; 2) be prescribed Retevmo® for an FDA-approved indication or an indication medically supported by CMS-recognized Compendia; 3) be 18 years of age or older or an Authorized Representative of a Patient under age 18; and 4) 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

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 4) This supply of Retevmo® is specifically for the Patient named above.

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

SAVINGS CARD TERMS AND CONDITIONS

UPDATED 09/2022

Terms and Conditions:

By using the Retevmo Savings Card ("Card"), you attest that you meet the eligibility criteria, agree to, and will comply with the terms and conditions described below:

Offer good for up to 12 months from patient qualification into the program. Patients must have coverage for Retevmo through their commercial drug insurance coverage to pay as little as $0 for a 30-day supply of Retevmo. Offer subject to a monthly cap and a separate annual cap. Monthly and annual caps are set at Lilly's absolute discretion and may be changed by Lilly with or without notice. Participation in the program requires a valid patient HIPAA authorization. Offer void where prohibited by law. Patient is responsible for any applicable taxes, fees, or amounts exceeding monthly or annual caps. **This offer is invalid for patients without commercial drug insurance or whose prescription claims for Retevmo are eligible to be reimbursed, in whole or in part, by any governmental program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any State Patient or Pharmaceutical Assistance Program**. This offer is not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. Available only in the US and Puerto Rico for residents of the US and Puerto Rico who are 18 years of age of older. By accepting this offer, you agree that if you are required to do so under the terms of your insurance coverage for this prescription or are otherwise required to do so by law, you should notify your Insurance Carrier of your redemption of this Card. This offer cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, incentive, or similar offer involving Retevmo. It is prohibited for any person to sell, purchase or trade; or to offer to sell, purchase or trade, or to counterfeit this Card. This offer may be terminated, rescinded, revoked or amended by Lilly USA, LLC at any time without notice. Card activation required. This Card is not health insurance. Program expires at the end of each calendar year.

UPDATED 09/2022

What to Know About the Retevmo® Ongoing Support Program:

Your healthcare provider has talked with you about using Retevmo®, an Eli Lilly and Company medicine. The Lilly Oncology Support Center™ was created to help you have a positive experience as you get started with and use this medicine. The Lilly Oncology Support Center™ offers personalized support to Patients at no charge.

OPTIONAL RETEVMO® ONGOING SUPPORT ENROLLMENT CONSENT

Ongoing Support Enrollment Consent:

The Ongoing Support Services included in the Lilly Oncology Support Center™ provide support after you've received your medication, like check-in calls to answer any questions you might have about Retevmo®. As part of your participation in the Ongoing Support Services, Eli Lilly and Company and 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.

Services include:

Contacting you by email, mail or telephone to provide personalized services, delivered by your Lilly Oncology Support Center™ team, such as information and marketing materials; responding to customer service requests and/or questions about your treatment; requesting feedback on your experience with the related products, services, and programs, including market research and medical research; disclosing your enrollment 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 not part of the Lilly Oncology Support Center™. These activities include opportunities to share your story and participate in studies about products and services. To cancel your participation in the program, please contact us at **1-866-472-8663** Mon-Fri, 8am–10pm ET.

UPDATED 09/2022

Privacy Notice:

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.

Your information may be combined with other information that you have previously provided or that Lilly has received. We do not sell personal information.

We may transmit personal information about you to other Lilly affiliates worldwide. These affiliates may in turn transmit personal information about you to other Lilly affiliates. Some of Lilly's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Lilly's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about Lilly's privacy practices, including the basis for transfers and safeguards that Lilly has in place for cross-border transfers of personal information, please contact us at privacy@lilly.com or visit https://www.lilly.com/privacy.

We provide reasonable physical, electronic and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Lilly. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches.

Upon verification, you have the right to request information from us regarding how your personal information is being used and with whom that information is being shared. You also have the right to request to see and get a copy of the personal information that we have about you, request its correction or request its erasure/deletion.

There may be exceptions that apply to your request.

In limited circumstances, you may have the right to have your information transmitted to another entity or person in a machine-readable format.

You will not be discriminated against for exercising any of your rights.

To exercise your rights, you or your authorized representative may submit a request by contacting us using one of the methods listed below.

You may make any of the above requests by contacting us at: The Lilly Answers Center, Lilly USA, LLC, Lilly Corporate Center, Indianapolis, IN 46285 or by calling 1-800-545-5979.

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).