Lilly Support Services™

PATIENT ENROLLMENT SECTION
Retevmo® (selpercatinib)

PUBLISHED 05/2025

HAVE YOUR PATIENT SCAN to add Lilly Support Services™ for Retevmo® to their phone contacts

SUBMIT COMPLETED PAGES 1-4 VIA FAX AT 1-877-427-4030.

For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday, 8am-10pm ET.

THIS PAGE MUST BE SUBMITTED

Section 1: Patient Information

Patient Name (First, MI, Last) _____ **Date of Birth** (MM/DD/YYYY) _____

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

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

Phone* (000-000-0000) _____ **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 (000-000-0000) _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

RX BIN _____ **PCN** _____

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. Lilly Support Services™ for Retevmo® 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™ for Retevmo®. As part of your participation in Lilly Support Services™ for Retevmo®, 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™ for Retevmo® 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™ for Retevmo®. 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) Monday-Friday, 8am-10pm 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.

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PRESCRIBER ENROLLMENT SECTION
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Section 4: Prescriber information

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

Practice Name _____ **Office Phone (000-000-0000)** _____

Office Fax (000-000-0000) _____ **Office Address** _____

Office City _____ **Office State** _____ **Office Zip** _____ **Group Tax ID** _____

Office Contact Name _____ **Office Contact Phone (000-000-0000)** _____

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

Section 5: Diagnosis

Name of Patient (First, MI, Last) _____

Patient DOB (MM/DD/YYYY) _____ **Patient Address** _____

Patient City _____ **Patient State** _____ **Patient 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 2 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
- ☐ Adult and pediatric patients 2 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)
- ☐ Adult and pediatric patients 2 years of age and older with locally advanced or metastatic solid tumors with a *RET* gene fusion, as detected by an FDA-approved test, that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options*
- ☐ Diagnosis supported by CMS-recognized compendia and not unsupported in any CMS approved compendia

*This indication is approved under accelerated approval based on overall response rate (ORR) and duration of response (DoR). Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Section 6: HCP Service Selection & Prescription

Benefits Investigation Support (select one)

☐ **Lilly Conducted Benefits Investigation**–Lilly Support Services™ for Retevmo® 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 Support Services™ for Retevmo® representative will help triage and troubleshoot access issues on the Patient's behalf.
IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION BELOW.

☐ **Specialty Pharmacy Conducted Benefits Investigation**–

Specialty Pharmacy where prescription was sent _____

Specialty Pharmacy Phone Number (000-000-0000) _____

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 orally twice daily	60 Tablets (30 day supply)	**Refills (1-11)** _____
☐ 120mg orally twice daily	60 Tablets (30 day supply)	
☐ 80mg orally twice daily	60 Tablets (30 day supply)	
☐ 40mg orally three times daily	90 Tablets (30 day supply)	
☐ 40mg orally twice daily	60 Tablets (30 day supply)	
☐ 40mg 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

Please continue to the next page.

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HIPAA AUTHORIZATION

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You have selected Eli Lilly and Company ("Lilly") to coordinate certain services related to your health and to provide information related to your health (Lilly's "Programs and Services"). In order for Lilly to offer the Programs and Services, Lilly may need to obtain or exchange your protected health information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") from your Health Care Entities (as defined below). PHI can be inclusive of "sensitive data" as defined by applicable U.S. privacy laws. After your PHI has been released to Lilly, it is no longer covered by HIPAA. By signing this form, you understand and authorize your Health Care Entities to share your PHI with Lilly and use as explained below.

PHI includes the following individually identifiable information:

- Information about your health insurance or benefits, including how much coverage you have
- All relevant records about your treatment, including medication histories and prescriptions
- Information about your payment for treatment, including any insurance coverage
- Whether you're staying on your medicine or treatment

If you agree, your PHI may be collected from and 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

How Your PHI Will Be Used

Your PHI will be used to enroll you in, provide you with, and operate and administer the Programs and Services, consistent with Lilly's Privacy Statement and Consumer Health Privacy Notice, including to:

- understand how much of your Lilly treatment is covered by your insurance
- help you find ways to afford such treatment
- track the shipment, receipt, and use of your Lilly treatment and Programs and Services
- share information with your Health Care Entities and communicate with them regarding Lilly Programs and Services
- contact you about Lilly Programs and Services related to your health needs
- measure Lilly Programs and Services' performance in order to make improvements and drive business decisions and metrics
- de-identify your data for analytics including reports about Health Care Entities' use of Lilly Programs and Services.

Please continue to the next page.

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Other things you should know about how we may use and share your PHI:
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 Lilly and its wholly owned subsidiaries ("Lilly" or "we") and/or entities or persons that work on behalf of, or in partnership with, Lilly but are not Lilly employees ("Third Parties").

- You don't have to give permission to share your PHI with Lilly to receive treatment from your Health Care Entities, your prescription from your pharmacy, or benefits from your healthcare plan, but Lilly Programs and Services may not be able to help you without your Authorization.
- Your Health Care Entities may receive compensation from 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.
- Your signed authorization to share and use your PHI lasts for the duration of your participation in Lilly Programs and Services from the date of your signature or earlier as required by state law. In any case, you may revoke this Authorization for Lilly Programs and Services and you may request to obtain PHI from your Health Care Entities at any time by writing to PO Box 501847, San Diego, CA 92150. Your revocation of this Authorization will not have any effect on any uses or disclosures of your PHI that occurred prior to Lilly's receipt of your revocation.
- **Your 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 prior to receipt of the notice.**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my Health Care Entities to disclose my PHI and sensitive data for the purposes as described in this HIPAA Authorization. This HIPAA Authorization replaces any prior HIPAA Authorizations that I may have provided at a specific program level.

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 Minor Patient. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient or Authorized Representative _____
Not signing this form will result in an incomplete submission and a delay in requested services

Printed Name of Patient or Authorized Representative _____

Signature Date (MM/DD/YYYY) _____

Patient or Authorized Representative DOB (MM/DD/YYYY) _____

Authorized Representative's Relationship to Patient _____

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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).