Lilly Support Services™

PATIENT ENROLLMENT SECTION

Kisunla™ (donanemab-azbt)
injection for IV infusion

PUBLISHED 07/2025

OFFICE: Complete the entire form and submit pages 1-5 to Lilly Support Services™ via fax at 1-844-731-2697 or complete online at https://enroll.lillysupportservices.lilly.com. For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday 9am – 6pm ET.

Items with † on pages 1-5 are required to complete enrollment.

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).

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**

Primary Contact Communication Preferences: Method ☐ 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 (If checked, information below is required†)**

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 (If checked, information below is required†)**

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.

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Lilly Support Services™

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 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067. 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. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient† _____

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

Printed Name of Patient _____

Date Signed† (MM/DD/YYYY) _____

DOB (MM/DD/YYYY) _____

Lilly Support Services™

PRESCRIBER ENROLLMENT SECTION

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Section 5: Prescriber Information

Prescriber 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

DESCRIPTION OF AVAILABLE SERVICES

Benefits Investigation: Researches the Patient's insurance to help identify the lowest out-of-pocket cost available for Kisunla™.

Care Coordination: Optional service that coordinates reimbursement and adherence requirements (such as MRIs or other medical documentation) across a Patient's Kisunla™ treatment team. If selected, Lilly Support Services™ will request the HCP to routinely submit information via our Care Coordination Form. Care Coordination also includes outreach to the Site of Care (HCP Office or Infusion Center) to collect infusion appointment dates.

Infusion Center Locator Support: Helps your Patient locate a convenient infusion site to receive their Kisunla™ treatment.

Nurse Navigators: Service included for all Patients enrolled in Lilly Support Services™ for Kisunla™. Nurses partner with Patients through their Kisunla™ treatment journey by offering resources, answering questions, and providing emotional support.

SERVICE SELECTION

Select from the following service offerings. Please use the "DESCRIPTION OF AVAILABLE SERVICES" above as a reference.

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

☐ **HCP or Infusion Center Conducted Benefits Investigation**

OR

☐ **Lilly Conducted Benefits Investigation**

Note about Savings Cards: As part of a Lilly Conducted Benefits Investigation, Lilly Support Services™ can research a Patient's insurance to determine eligibility for a Savings Card (Governmental beneficiaries are excluded from Savings Card eligibility; Terms and Conditions apply)

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

- ☐ 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™, who will complete the coverage attempt?

☐ **Prescribing HCP**

OR

☐ **Referred Infusion Center**

Care Coordination: Would you like to opt in to optional Care Coordination, which includes regular outreach from Lilly Support Services™?

☐ Yes, Prescriber is opting in to Care Coordination

Infusion Center Locator Support: Do you need assistance locating an Infusion Center?†

☐ **Yes, Prescriber is requesting support in locating an Infusion Center**

OR

☐ **No, Prescriber is referring to the following known treatment 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** _____

☐ **In-Office Infusion Center (same address as in Section 5)**

Office/Hospital/Other Name _____

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

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

NPI # _____ **PTAN #** _____

Lilly A MEDICINE COMPANY

Lilly Support Services™

PRESCRIPTION AND INFUSION ORDER FORM

Kisunla™ (donanemab-azbt)
injection for IV infusion

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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†

You must select at least one Dosing option. You may select multiple Dosing options if they are in sequential order.

Kisunla™ Dosing - Infuse intravenously once every 4 weeks per the dosing schedule below	Quantity	Days Supply	Refills
STARTING DOSES			
☐ Infusion 1: Infuse 350 mg intravenously over approximately 30 minutes	1 vial	28	NA
☐ Infusion 2: Infuse 700 mg intravenously over approximately 30 minutes	2 vials	28	NA
☐ Infusion 3: Infuse 1050 mg intravenously over approximately 30 minutes	3 vials	28	NA
CONTINUED DOSE			
☐ Infusion 4+: Infuse 1400 mg intravenously over approximately 30 minutes once every 4 weeks thereafter	4 vials	28	_____

Section 9: Infusion Order Information Protocol

Administration Protocol:

- 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

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