Lilly Support Services™

EBGLYSS® (lebrikizumab-lbkz)

ADULT AND PEDIATRIC ENROLLMENT FORM
PUBLISHED 05/2026

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HOW TO SUBMIT

Send all pages and insurance information via
Fax: 1-833-324-0051

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

▸ **All pages must be submitted** to process this enrollment.

† Indicates a **required field**. Items marked † must be completed to avoid delays in enrollment.

SECTION 1: PATIENT INFORMATION

Name (First MI Last)† _____ *Patient DOB (MM/DD/YYYY)†* _____ *Gender* ◯ *M* ◯ *F* *Language (if not English)* _____

Address (no PO Box)† _____ *City†* _____ *State†* _____ *Zip†* _____

Email† _____ *Phone†* _____ *Voicemail OK?* ☐ *Yes*

☐ *By checking the box, I agree to receive automated marketing calls and texts from and on behalf of Eli Lilly and Company. Voicemails may include information about my participation in Lilly Support Services™ for EBGLYSS®. 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.

Authorized Representative – *Required if Patient is under age 18*

Authorized Representative Name _____ *Authorized Representative DOB (MM/DD/YYYY)* _____ *Relationship to Patient* _____

HIPAA Authorization — Signature required

I confirm that I have **read in full** the Patient Authorization to Use and Disclose Health Information set forth in **Section 7 (pages 4 & 5)** of this form, and I agree to its terms. By signing below, I am authorizing the uses and disclosures of my protected health information described in Section 7.

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.

IMPORTANT: Before signing below, please **turn to Section 7 (pages 4 & 5) and read the Patient Authorization to Use and Disclose Health Information in full**. Your signature below confirms that you have reviewed Section 7 in its entirety and agree to its terms.

SIGN† _____
Patient or Authorized Representative if Patient is under age 18

TODAY'S DATE (MM/DD/YYY)† _____

Printed Name of Patient or Authorized Representative _____

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

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SECTION 2: INSURANCE INFORMATION

◯ **I have included a copy of the patient's insurance cards (front and back) or information** ◯ **Patient has NO insurance**

Tip: To expedite the Benefits Investigation process, please also include a copy of the patient's **pharmacy benefit card (front and back).** This helps Lilly Support Services™ for EBGLYSS® identify all available coverage options quickly.

Primary Prescription Insurance Company _____ **Insurance Phone # (000-000-0000)** _____

Cardholder Name _____ **Policy/ID** _____ **Group #** _____ **RX BIN** _____ **PCN** _____

SECTION 3: SERVICES, BENEFITS INVESTIGATION AND SPECIALTY PHARMACY

Patient Services (Must be completed by the Patient)

Patient, please select which services you would like to enroll in by checking the corresponding checkboxes below. By enrolling in any of these services, you are agreeing to the Terms of Participation and consenting to the collection of your information as described in Section 8.

☐ **1. Savings Card:** Provides eligible, commercially-insured Patients with options to save on treatment costs. **Please review full Savings Card Terms and Conditions in section 9 (page 6).**

Savings Card eligibility — must confirm both to be eligible

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

☐ I confirm that I have reviewed and agree to the Terms and Conditions on page 6 and attest that I am eligible to participate in this program

☐ **2. Sharps Disposal: Provides a free Sharps disposal container for Lilly injectable devices**

☐ **3. Injection Training: Provides step-by-step education from a Registered Nurse on how to appropriately self-inject the medication**

By submitting this enrollment form, Lilly Support Services™ for EBGLYSS® will be able to view patient information and provide program support services and resources to eligible patients.

Terms of Participation: To cancel participation in the program, please contact us at 1-800-LillyRx (1-800-545-5979) Monday–Friday, 8am–10pm ET.

HCP Services† (Must be completed by the prescriber or office staff)

Select one option below.

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

OR

◯ **Specialty Pharmacy Conducted Benefits Investigation—IF CHECKED, MUST COMPLETE FIELDS BELOW.**
Specialty Pharmacy where prescription was sent will conduct the Benefits Investigation. I have sent or will send this prescription to the specialty pharmacy listed below.

Specialty pharmacy name _____ Phone _____

Lilly Support Services™ for EBGLYSS®

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

SECTION 4: DIAGNOSIS

Diagnosis (select one)†:

◯ **L20.9 Atopic dermatitis, unspecified** ◯ **L20.89 Other atopic dermatitis** ◯ **Other ICD-10-CM Code** _____ *(please complete, if "Other" is selected)*

SECTION 5: PRESCRIBER INFORMATION

Prescriber Name† _____ **Prescriber NPI #†** _____

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

Site/facility name _____ **Tax ID** _____ **Phone†** _____ **Fax†** _____

Office Contact Name _____ **Office Contact Email** _____

Collaborating MD name _____ **Collaborating MD NPI #** _____

SECTION 6: RX: EBGLYSS® (LEBRIKIZUMAB-LBKZ) 250MG/2ML PRESCRIPTION

Complete the prescription and sign where indicated.

STEP 1 – Select Device Type†
Do not leave blank

◯ **Prefilled Pen**

OR

◯ **Prefilled Syringe**

Known drug allergies / prior treatment failures

_____

_____

_____

_____

_____

_____

STEP 2 – Select Dosing†
If Patient is 12–17 years of age, they must be ≥40 kg (88 lbs)

Dose / Instructions	Quantity	Units	Day Supply	Refills
INITIAL DOSE (MUST SELECT ONLY ONE)				
◯ **If no sample boxes were given** 500mg/4mL (2 x 250mg/2mL) given as two subcutaneous injections (at weeks 0 and 2)	4 boxes	**8 mLs**	28	0
◯ **If 1 sample box was given** 500mg/4mL (2 x 250mg/2mL) as two subcutaneous injections (at weeks 0 and 2)	2 boxes	**4 mLs**	14	0
◯ **If 2 sample boxes were given** Initial Dose Complete ▸ Must Select Induction Dose below	N/A	N/A	N/A	0
INDUCTION DOSE				
☐ 1 x 250mg/2mL injection (every 2 weeks at weeks 4-14) If additional induction dosing is needed, contact your pharmacy	4 boxes	**4 mLs**	28	2
MAINTENANCE DOSE (SELECT ONLY ONE, please complete refills selection in the table)				
◯ **Option A — Every 4 Weeks (Q4W)** 1 x 250mg/2mL injection (every 4 weeks at weeks 16 and thereafter) *For reference, 1 year of treatment equals 8 refills during maintenance*	1 box	**2 mLs**	28	_____ *(1–8)*
OR				
◯ **Option B — Every 8 Weeks (Q8W)** 1 x 250mg/2mL injection (every 8 weeks at weeks 16 and thereafter) *For reference, 1 year of treatment equals 4 refills during maintenance*	1 box	**2 mLs**	56	_____ *(1–4)*

By signing below, I certify: 1) The therapy is medically necessary and information is accurate to the best of my knowledge; 2) I am disclosing this information to Eli Lilly and Company, Lilly USA, LLC, and their affiliates, agents, representatives, business partners, and service providers ("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 the 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 EBGLYSS® pursuant to an FDA approved indication. **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE.** Rubber stamps, signatures by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

☐ By checking this box, I confirm that the Patient has provided express consent to be contacted by automated text messaging from Eli Lilly and Company, and parties working on their behalf, to complete enrollment in Lilly Support Services™ for EBGLYSS®.

Prescriber signature† *(NO stamps — prescriber must manually sign and date)*

Dispense as written† _____ **SIGN†** _____ **Date† (MM/DD/YYYY)**

OR

Substitutions permitted _____ **SIGN†** _____ **Date† (MM/DD/YYYY)**

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PATIENT — Please read carefully, then sign and date where indicated in Section 1 on Page 1

SECTION 7: PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

This is the Patient Authorization to Use and Disclose Health Information referenced in the signature block on page 1. By signing on page 1, you are authorizing the uses and disclosures of your protected health information described in this Section 7. Please read this Section in full before signing.

HIPAA Authorization

By my agreement below, I hereby authorize my Health Care Entities (defined below) to disclose to Eli Lilly and Company, its subsidiaries and affiliated entities (collectively " Lilly") my health information, which may include protected health information ("PHI") identified below for the purposes outlined below, in compliance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and applicable privacy laws (collectively, "Applicable Privacy Laws").

PHI includes the following individually identifiable information:

- Your demographic information which may include name, age, DOB, email, address and phone number
- Information about your health insurance or benefits, including your level of coverage and payment for treatment
- All relevant records about your treatment, medical conditions, including medication history, prescriptions and adherence

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 Lilly programs and services, consistent with Lilly's Privacy Statement, 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 use of our programs and services
- share information with your Health Care Entities and communicate with them regarding Lilly programs and services
- contact you about Lilly treatments, programs and services that may be of interest to you or related to your health needs
- measure the performance of Lilly programs and services to make improvements and drive business decisions and metrics
- combine your PHI with other information you have provided to Lilly through other programs, platforms, or registrations for the purposes described in this Authorization
- de-identify your data for analytics including reports about Health Care Entities' use of Lilly programs and services
- for marketing and promotional purposes, such as sending you marketing communications and information about Lilly services, market research, clinical research opportunities and other product offerings.

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SECTION 7: PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION (Cont.)

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/or entities or persons that work on behalf of, or in partnership with, Lilly but are not Lilly employees.

- 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 may be limited in providing certain programs and services.
- 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. This HIPAA authorization replaces any prior HIPAA authorizations you may have provided at a specific program level.
- After your PHI has been released to Lilly, it may no longer be covered by HIPAA. In this case, your data will be treated as required by applicable state laws.
- **If you wish to revoke this Authorization, send your revocation in writing to PO Box 221349, Charlotte, NC 28222. 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.**
- **You can obtain a copy of this Authorization at any time by calling us at 1-866-691-4533.**

By signing this form, I confirm that I have read and agree to the Patient HIPAA Authorization for myself or on behalf of the Patient.

SECTION 8: TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES

Your healthcare provider has talked with you about using EBGLYSS®, an Eli Lilly and Company medicine. Lilly Support Services™ for EBGLYSS® 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 checking the corresponding optional boxes on page 1, you consent to your enrollment into Lilly Support Services™ for EBGLYSS®. As part of your participation in Lilly Support Services™ for EBGLYSS®, 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 EBGLYSS® 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 EBGLYSS®.

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.**

You may keep a copy of this form for your records.

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SAVINGS CARD TERMS AND CONDITIONS

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

Card Eligibility:

(1.) You have been prescribed EBGLYSS® (lebrikizumab-lbkz) for an approved use consistent with FDA-approved product labeling;
(2.) You are enrolled in a commercial drug insurance plan;
(3.) **You are not enrolled in any state, federal, or government funded healthcare program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medicare Advantage, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state prescription drug assistance program;**
(4.) You are a resident of the United States or Puerto Rico; and
(5.) You are 18 years of age or older.

Card Terms and Conditions:

For patients with commercial drug insurance coverage for EBGLYSS: You must have commercial drug insurance that covers EBGLYSS and a prescription for an approved use consistent with FDA-approved product labeling to pay as little as $5 for a 1-month prescription fill of EBGLYSS. Month is defined as 28 days and up to 4 pens. Card must be first used by no later than 12/31/2026. Card savings are subject to a maximum monthly savings of wholesale acquisition cost plus usual and customary pharmacy charges and a separate maximum annual savings of up to $10,600 per calendar year. Card may be used for a maximum of up to 14 prescription fills per calendar year, subject to the previously stated maximum monthly and annual savings limit. Except where prohibited by applicable state law, Card monthly and annual savings are reduced if Lilly identifies that you are enrolled in a plan or program, sometimes called a maximizer plan, that adjusts your cost sharing amount to be equal to or include some portion of the savings provided by the Card and attempts to prevent the savings from this Card from being applied to your out-of-pocket costs, including but not limited to copayments, coinsurances, and deductibles ("Maximizer"). If the Program identifies you are enrolled in a Maximizer, Card savings are reduced to a maximum monthly savings of up to $25 and a separate maximum annual savings of up to $350 per calendar year. If you have reason to believe that the Program erroneously identified enrollment in a Maximizer, please call the Ebglyss Savings Card Program at 1-800-LillyRx (1-800-545-5979). Participation in the Program requires a valid patient HIPAA authorization upon enrollment into the Program. Subject to Lilly USA, LLC's right to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2028 or 24 months after you first use the Card, whichever comes first.

For patients with commercial drug insurance who do not have coverage for EBGLYSS: You must have commercial drug insurance that does not cover EBGLYSS and a prescription for an approved use consistent with FDA-approved product labeling to pay as little as $25 for a 1-month supply of EBGLYSS. Month is defined as 28 days and up to 4 pens. Card savings are subject to a maximum monthly savings of wholesale acquisition cost plus usual and customary pharmacy charges, up to a maximum of 14 prescription fills per calendar year. Card must first be used by no later than 12/31/2026. Participation in the Program requires submission of a prior authorization (PA) prior to the first prescription fill. If coverage is denied, an appeal must be submitted prior to 5th month prescription fill. If coverage is denied, an appeal must be submitted prior to the 13th prescriptions fill. To remain eligible for the Program, a new PA appeal, or medical exception must be submitted prior to the 13th prescription fill and as required by Lilly at its sole discretion. Participation in the Program requires a valid patient HIPAA authorization to remain in the Program. Subject to Lilly USA, LLC's right to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions, which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2028 or 24 months after you first use the Card, whichever comes first.

Additional Program Terms and Conditions

If you have an insurance plan that is participating in an alternate funding program (AFP) that requires you to apply to the EBGLYSS Savings Card Program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of EBGLYSS, you are not eligible for and are prohibited from using the EBGLYSS Savings Card Program. AFPs include programs where coverage, reimbursement, or patient out of pocket costs for a product in some way vary based on the availability of a manufacturer co-pay program. AFPs may modify, delay, deny, restrict, or withhold insurance benefits or coverage from patients, or exclude Lilly products from coverage contingent upon a member's use of EBGLYSS Savings Card Program. You agree to inform EBGLYSS Savings Card Program if you are or become a member of such an alternative funding program. You are responsible for any applicable taxes, fees, and any amount that exceeds the monthly or annual maximum Card savings. Monthly and annual maximum savings are set at Lilly's sole and absolute discretion and may be charged with or without notice at any time for any reason. At its sole discretion and with or without notice, Lilly may reduce, eliminate, or otherwise modify the Card savings for any reason, including but not limited to if your commercial drug insurance plan imposes additional requirements which limits or prevents you from receiving coverage for EBGLYSS, only allows partial coverage for EBGLYSS, removes coverage for EBGLYSS and requires you to utilize the Card, does not provide a material level of financial assistance for the cost of EBGLYSS, or does not apply Card payments to satisfy your co-payment, deductible, or coinsurance for EBGLYSS. Lilly has the right to require patients with commercial drug insurance without coverage for EBGLYSS to use Lilly's designated pharmacy vendor(s) to obtain Program savings. Card savings are not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. You must meet the Card eligibility criteria, terms and conditions every time you use the Card. If at any time you begin receiving drug coverage under any state, federal, or government funded healthcare program, you understand that you will no longer be eligible for the EBGLYSS Savings Card and agree to call the EBGLYSS Savings Card Program at 1-800-545-5979 to stop participation. Card activation is required. You may not seek reimbursement from your health insurance, any third party, or any health savings, flexible spending, or other healthcare reimbursement accounts, for any amount of the savings received through the Card. By utilizing the Card, 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 will notify your Insurance Carrier of your redemption of the Card. Card savings cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, incentive, or similar offer involving EBGLYSS. You agree that this Card savings is intended solely for the benefit of you, the patient, and that the Card benefits are non-transferable. It is prohibited for any person to sell, purchase, or trade; or to offer to sell, purchase, or trade, or to counterfeit the Card. **THIS CARD IS NOT INSURANCE.** Lilly has the sole right to interpret and apply Card eligibility criteria, and terms and conditions. Card eligibility, and terms and conditions may be terminated, rescinded, revoked, or amended by Lilly at any time without notice and for any reason. Lilly's sole discretion to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions includes the right to terminate any individual Card if Lilly determines, in its sole discretion, that a patient does not satisfy the Card's eligibility criteria or is using or has attempted to use the Card inconsistently with these Terms and Conditions. Eligibility criteria, and terms and conditions for the EBGLYSS® Savings Card Program may change from time to time; the most current version can be found at https://ebglyss.lilly.com/savings-support#full-terms-and-conditions-panel. You may be required to obtain a new Card, including if any Card terms and conditions have been terminated, rescinded, revoked, or amended by Lilly. Card void where prohibited by law. Subject to Lilly's right to terminate, rescind, revoke or amend Card eligibility criteria and/or Card terms and conditions, which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2028 or 24 months after you first use the Card, whichever comes first.

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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).

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