taltz® (ixekizumab)

Prescription Information and Taltz Together™ Enrollment Form

Complete and fax this form to 1-844-344-8108.

All fields required, unless noted.

For questions or concerns, please call Taltz Together at **1-844-TALTZ-NOW** (1-844-825-8966).

1. Patient Information

Name (First, Middle, Last) _____

Sex: M ☐ F ☐ DOB (MM/DD/YYYY) _____

Address _____

City _____ State _____ ZIP Code _____

Email _____

Home/Cell Phone* _____

Work Phone _____ Best Time to Contact _____

Authorized Representative _____

Relationship to Patient _____

Phone Number _____

Email _____

***By providing my cell phone number and signing this form, I consent to receive automated (and/or prerecorded) calls and texts about the Taltz Together program at this number. I understand that I am not required to provide this number to participate in the program, but if I do not then I will not be able to receive certain status reminders and other program communications.**

2. Insurance Information

Include copy of the policyholder's insurance card (front and back) or complete the following information:

Primary Insurance Company _____

Policyholder _____

Relationship to Policyholder _____

Employer _____

Insurance Company Phone _____

Policy # _____

Group # _____

Rx BIN _____

PCN _____

First, check the patient's pharmacy coverage and then, if needed, check the patient's medical coverage. Along with including the pharmacy coverage, also include the patient's medical information, if available.

PATIENTS ARE REQUIRED TO FILL OUT HIPAA AUTHORIZATION SECTION ON BACK PAGE AND MAY OPT TO COMPLETE ONGOING SUPPORT ENROLLMENT CONSENT

3. Taltz Together Program Offerings (Optional)

Select the offerings below that either your patient or your office would like to receive:

☐ Preliminary Insurance Investigation	This step allows Taltz Together to help find the in-network specialty pharmacy option for your patients that will provide the lowest co-pay.
☐ Injection Training	Training is available to both patients and their family members, free of charge. This training can be completed in their homes, at an alternate location, or remotely over the phone.
☐ Field Reimbursement Support	Our Reimbursement Support Specialists can help your office answer questions related to the insurance investigation and approval processes.

4. Prescriber Information

By signing below, I certify that the therapy is medically necessary and that this information is accurate to the best of my knowledge. I also represent that I am disclosing this information to Eli Lilly and Company and Lilly USA, LLC, and its affiliates, agents, representatives, and service providers (together "Lilly") to help enable treatment for this patient. I further certify that 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. Additionally, I certify I am licensed to prescribe the prescription medication identified in this form and appoint Lilly as my agent for the limited purpose of conveying this prescription to the dispensing pharmacy.

Name (First, Last) _____ Practice Name _____

City _____ State _____ ZIP Code _____ Phone _____ Fax _____

Email _____ NPI # _____

Office Contact Name _____ Address _____

Office Contact Phone _____ Office Contact Email _____

Group Tax ID # _____ State License # _____ Specialty _____

5. Clinical Information (ICD-10 Code)

Primary Diagnosis: ☐ Psoriasis (L40.0) Date of Diagnosis or Years With the Disease _____ % BSA Affected _____

Prior Treatment (check all that apply)	Start Date - End Date (MM/DD/YYYY)	Reason for Discontinuation
☐ Methotrexate	-	
☐ Other systemic therapy _____	-	
☐ Enbrel®	-	
☐ Humira®	-	
☐ Remicade®	-	
☐ Stelara®	-	
☐ Other _____	-	

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6. Taltz Prescription Information

I certify that the below therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed Taltz to the previously identified patient and that I provided the patient with a description of Taltz Together. I authorize Taltz Together to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Injection Device (choose one): ☐ Autoinjector or ☐ Prefilled Syringe

Starting Dose: ☐ 2 x 80-mg (160-mg) subcutaneous injections Requested Ship Date _____

Ship to: ☐ Physician's Address ☐ Patient's Address

Induction Dose: ☐ 1 x 80-mg subcutaneous injection every 2 weeks (weeks 2-12) Requested Ship Date _____

Ship to: ☐ Physician's Address ☐ Patient's Address

Maintenance Dose: ☐ 1 x 80-mg subcutaneous injection every 4 weeks (after week 12)

Quantity to Be Dispensed: ☐ 1 month ☐ 2 months ☐ 3 months Refills _____

Ship to: ☐ Physician's Address ☐ Patient's Address

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN (RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER, AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED).

_____ ☐ Dispense as written Date _____

_____ ☐ Substitution/brand exchange permitted Date _____

Patient HIPAA Authorization

Before we can begin the process of assisting you, Lilly needs some information about you. To provide services to you, we need to collect, use, and disclose your Protected Health Information (PHI). Protected Health Information includes any information related to your healthcare insurance or plan benefits, including coverage limits; all health records related to your treatment; as well as any information that has a bearing on your health or whether you're staying on your medicine or treatment. Although we are not looking for Protected Health Information that is unrelated to your Lilly treatment, it may be part of the health records sent to us.

When signed by you, this form permits your Protected Health Information to be released to Eli Lilly and Company and Lilly USA, LLC, and its affiliates, agents, representatives, and service providers (together "Lilly") by your doctors, your healthcare plan or insurance company, your pharmacies, or others who might hold your Protected Health Information ("Healthcare Providers"). Once you sign this form and it is sent back to us, we can use the released health information to provide the support services described below.

You do not have to sign this consent, but we cannot provide our services without it. You might need to pay for your Lilly product on your own, whether you sign this form or not.

PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE. YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.

I understand that by signing this form, I authorize my doctors, my healthcare plan or insurance company, my pharmacies, or others who might hold my Protected Health Information to release it to Lilly, who is performing services related to this program.

My Protected Health Information may be used to help determine my healthcare plan coverage for Lilly treatments prescribed by my doctor and other procedures as part of my therapy on Lilly treatments; make me aware of alternate funding sources for my treatment; facilitate my access to Lilly treatment; identify or track my use of prescribed Lilly treatments; manage the Taltz Together program, including contacting me to collect additional information to perform those services by email or other means with the contact information I've provided; conduct quality assurance, surveys or other internal business activities in connection with the Taltz Together program; and share information with my Healthcare Providers relating to my participation in Taltz Together, including personal information and information about my prescription drugs.

I understand that certain of my Healthcare Providers (such as pharmacies and specialty pharmacies) may receive remuneration (payment) from Lilly in exchange for disclosing my Protected Health Information and/or for using my information to provide me with therapy support services such as to contact me with communications about Lilly products.

I understand that once my Healthcare Providers release my Protected Health Information, my Protected Health Information may no longer be covered by Federal and State Privacy Laws (for example, HIPAA) and may be re-disclosed.

This authorization allows those who rely on it to release my Protected Health Information for 1 year from the date I have signed it. I can withdraw it at any time by sending a written notice to PO Box 12037, La Jolla, CA 92039, or by calling 1-844-TALTZ-NOW (1-844-825-8966). My withdrawal goes into effect once it is received by the program.

I understand that by signing below I am providing legal authorization for Lilly to use and share, and for my Healthcare Providers to disclose, my personal information including my Protected Health Information for the purposes described above.

Signature of Patient or Personal Representative* _____ Date _____

Print Patient's Name _____ Date _____

Personal Representative's Name (if applicable) _____ Date _____

*An individual authorized to act on behalf of the patient in accordance with state law.

Ongoing Support Enrollment Consent (Optional)

Taltz Together is a customized support program offered by Eli Lilly and Company and its business partners (together, "Lilly"). As part of my participation, Lilly may use, disclose and/or transfer the personal information I supply to provide services related to my condition and treatment to administer the program. Those services include contacting me by email, mail or telephone to provide personalized service delivered by my Companion in Care™ including informational and marketing materials; respond to customer service requests and/or product questions; request feedback on my experience with the related products, services and programs including market research; disclose my enrollment and use of these services to my healthcare providers and insurers; and analyze and/or measure program performance or future enhancements.

By signing below I agree to the statement above and certify that I am at least eighteen (18) years of age.

Signature of Patient _____ Date _____

To cancel your participation in the program, please contact us at **1-844-TALTZ-NOW** (1-844-825-8966).

Lilly