taltz® (ixekizumab)

Prescription Information and Taltz Together™ Enrollment Form

- Please fax the signed form (**FRONT AND BACK**) to **1-844-344-8108**
- For questions or concerns, please call Taltz Together at **1-844-TALTZ-NOW** (1-844-825-8966)

All fields required, unless noted.

1. Patient Information

Name (First, Middle, Last) _____ Sex: M ☐ F ☐ DOB (MM/DD/YYYY) _____

Address _____ City _____

State _____ ZIP Code _____ Email _____ Phone Number* _____ Best Time to Contact _____

Authorized Representative _____ Relationship to Patient _____

Phone Number* (Authorized Representative) _____ Email (Authorized Representative) _____

*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.

I have read and agree to the Patient HIPAA Authorization on the back of this form. ☐ I consent to my enrollment in the Taltz Together program outlined on the back of this form (optional).

✕ _____	_____	_____	_____	_____
Signature of Patient	**Print Patient's Name**	**Signature of Authorized Representative** (An authorized representative is an individual authorized to act on behalf of the patient in accordance with state law.)	**Print Authorized Representative's Name** (if applicable)	**Date (MM/DD/YYYY)**

2. Insurance Information

☐ Copy of the policyholder's insurance card (front and back) is attached **OR**

☐ Complete the following insurance information:

Primary Insurance Company _____ Policyholder _____ Insurance Company Phone _____

Primary # _____ Group # _____ Rx BIN _____ PCN _____

3. Support Services Requested for This Patient

PATIENTS ARE REQUIRED TO SIGN THE HIPAA AUTHORIZATION ABOVE

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

☐ **Insurance Investigation**
Includes Field Reimbursement Support

- OR -

☐ **Field Reimbursement Support Only**

_____
Name of Specialty Pharmacy - Must be one of the Taltz contracted specialty pharmacies

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

☐ Injection Training
☐ Sharps Disposal Service

4. Prescriber Information

Name (First, Last) _____ NPI # _____

Address _____

City _____ State _____ ZIP Code _____

Office Contact Name _____

Office Contact Phone _____ Office Contact Fax _____ Office Contact Email _____

Group Tax ID # _____ State License # _____

5. Clinical Information

Primary Diagnosis: ☐ **Plaque Psoriasis (ICD-10 Code: L40.0)** **Date of Diagnosis or Years With the Disease** _____ **% BSA Affected** 0.00%

☐ To my knowledge, the patient has not previously been treated with a biologic or systemic agent for the diagnosed condition.

If patient has been treated with a biologic or systemic agent, please provide information below.

Does this patient have a contraindication, intolerance, or allergy to Cosentyx®, Enbrel®, Humira®, Otezla®, Remicade®, Stelara®, or other biologic/systemic treatment?

☐ No ☐ Yes _____

Does this patient have documented failure of adequate trial on Cosentyx®, Enbrel®, Humira®, Otezla®, Remicade®, Stelara®, or other biologic/systemic treatment?

☐ No ☐ Yes _____

☐ Methotrexate	From _____ To _____	☐ Humira®	From _____ To _____	☐ Stelara®	From _____ To _____
☐ Cosentyx®	From _____ To _____	☐ Otezla®	From _____ To _____	☐ Other _____	From _____ To _____
☐ Enbrel®	From _____ To _____	☐ Remicade®	From _____ To _____		

6. Taltz Prescription Information (Complete This Section Only When Requesting Insurance Investigation)

Device	Dose	Quantity	Day Supply	Refills
☐ Autoinjector (80 mg/mL) **OR** ☐ Prefilled Syringe (80 mg/mL)	☐ **Starting Dose:** 160 mg (2 x 80 mg) subcutaneous injections on Day 1, then begin first induction dose (1 x 80 mg) 2 weeks later (week 2)	3 pens/syringes	28	0
	☐ **Induction Dose:** 1 x 80 mg subcutaneous injection every 2 weeks (weeks 4-10)	2 pens/syringes	28	1
	☐ **Final Induction Dose:** 1 x 80 mg subcutaneous injection (week 12)	1 pen/syringe	28	0
	☐ **Maintenance Dose:** 1 x 80 mg subcutaneous injection every 4 weeks (thereafter)	1 pen/syringe	28	_____

Prescriber Signature

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.

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN

Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

✕ _____ ✕ _____ **Date (MM/DD/YYYY)** _____

Dispense as written May substitute/brand exchange permitted

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 Lilly cannot provide the services described on this form without it. You might need to pay for your Lilly product on your own, whether you sign this form or not. If you don't sign this form, it will not affect any treatment, services or benefits you might receive from your doctor or pharmacy.

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 12307, 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. My Health Care Providers will no longer share my PHI with Lilly after the date that Lilly receives and processes my withdrawal letter, but this will not affect information or disclosures shared before that time.

I understand that by signing the front of this form 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.

Taltz Together 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 checking the corresponding box on the front of this form, I consent to my enrollment in the Taltz Together program outlined above.

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

Please fax the signed form (**FRONT AND BACK**) to **1-844-344-8108**.

Lilly