Lilly Cares
P.O. Box 13185
La Jolla, CA 92039
www.LillyCares.com
Phone: 1-800-545-6962
Fax: 1-844-431-6650

Lilly Cares Prescription FAX Form Forteo®

Patient Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Rx: I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy.

☐ **FORTEO® (teriparatide [rDNA origin] injection), 2.4-mL prefilled delivery device**
NDC 0002-8400-01

SIG/Directions: Inject 20 mcg subcutaneously daily

☐ Pen needles: BD™ Pen Needles 31G X 3/16" (5 mm) *(not included with delivery device)*

Quantity to Dispense:_____month supply *(max 4 mos.)* Refills: #_____(up to 1 year) Date:_____

Your state may require that prescriptions follow certain content requirements or use a particular form. By signing below you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing.

Signature: _____ _____
Dispense as written **Substitution/brand exchange permitted**

Supervising Physician Signature and Date *(where required)*: _____

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

Printed Prescriber Name and Title:_____

Prescriber State License Number and State: _____

Prescriber Telephone: _____Prescriber FAX: _____

Prescriber Address: _____

Confidentiality: IMPORTANT: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

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