

Lilly Cares Foundation Patient Assistance Program
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La Jolla, CA 92039
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www.LillyCares.com



LillyCares Prescription FAX Form Taltz®

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.

TALTZ® (ixekizumab) injection, for subcutaneous use

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

Please indicate patient's treatment plan (by check mark):

Taltz® is indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy

For psoriatic arthritis patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis.

Starting Dose: 2 x 80 mg (160 mg) subcutaneous injections

Next Two Induction Doses: 1 x 80 mg subcutaneous injection every 2 weeks (weeks 2-4) Quantity to be dispensed is 2 doses.

Remaining Induction Doses: 1 x 80 mg subcutaneous injection every 2 weeks (weeks 6-12) Quantity to be dispensed is 4 doses.

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

OR

Taltz® is indicated for the treatment of adult patients with active psoriatic arthritis.

For psoriatic arthritis patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis.

Starting Dose: 2 x 80 mg (160 mg) subcutaneous injections

Maintenance Dose: 1 x 80 mg subcutaneous injection every 4 weeks

Ship initial starting doses to:

- Prescriber's address below (injection training, then future doses shipped to patient's home)
 Patient's address

Quantity to be Dispensed: 4 months (max) 3 months 2 months 1 month

Refills: # _____ (up to one year of treatment) 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. I authorize Lilly Cares to act on my behalf for the limited purposes of transmitting this order for prescription medication.

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: _____ FAX: _____

State License Number and State: _____ Phone: _____

Prescriber Office/Clinic Name and Shipping Address (No PO Box) : _____

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.