

The Lilly Cares® Foundation Patient Assistance Program (“Lilly Cares”)

Prescription FAX Form

OmvoH™ (mirikizumab-mrkz) 300mg/15mL infusion | 100mg/mL injection

Patient Information:

Patient Name: _____ Date of Birth: _____ Today's Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____ Phone: _____
 Ship to Address (if different from patient address above, No P.O. Box or third-party vendor):

 City: _____ State: _____ Zip Code: _____
 Drug Allergies: _____
 Other Medications: _____

Rx: I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy. To submit an electronic prescription, please select Fortrea Specialty Pharmacy (NPI 1780811125) in your eRx software.

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

Type of Last OmvoH Treatment (Select ONE)	OmvoH Dosing Phase	Directions	Quantity	Refills
<input type="checkbox"/> Not started yet Anticipated Infusion Date: _____ <input type="checkbox"/> Infusion 1 <input type="checkbox"/> Infusion 2 <input type="checkbox"/> Infusion 3 <input type="checkbox"/> Subcutaneous	<input type="checkbox"/> Induction Dose: 300 mg / 15 mL single dose vial for intravenous infusion	300 mg intravenously at Weeks 0, 4, and 8	<input type="checkbox"/> 3 months (max) <input type="checkbox"/> 2 months <input type="checkbox"/> 1 month	
	<input type="checkbox"/> Maintenance Dosing: 2 prefilled pens x 100 mg /mL given as two consecutive SC injections	2 prefilled pens (200 mg) subcutaneously every 4 weeks	<input type="checkbox"/> 4 months (max) <input type="checkbox"/> 3 months <input type="checkbox"/> 2 months <input type="checkbox"/> 1 month	

Your state may require that prescriptions follow certain content requirements or use a particular form. Non-compliance with state-specific requirements will result in outreach to the prescriber and may delay shipping of medication. 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

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): _____

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.