

**The Lilly Cares® Foundation Patient Assistance Program (“Lilly Cares”)
Prescription FAX Form Taltz® (ixekizumab) injection 80 mg/mL**

Patient Information:

Patient Name: _____ Date of Birth: _____

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.

Taltz® injection, for subcutaneous use

Injection Device (choose one): Autoinjector or Prefilled Syringe (≤50 kg [110 lbs] use prefilled syringe)

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

Taltz® is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy. For adult patients with psoriatic arthritis and coexistent moderate to severe plaque psoriasis, follow the dosing 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

1. Taltz® is indicated for adult patients with active psoriatic arthritis.
For adult patients with psoriatic arthritis and coexistent moderate to severe plaque psoriasis, follow the dosing for plaque psoriasis.

2. Taltz® is indicated for adult patients with active ankylosing spondylitis.

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

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

OR

Taltz® is indicated for adult patients with active non-radiographic axial spondyloarthritis with objective signs of inflammation.

Dose: 1 x 80 mg subcutaneous injection every 4 weeks

OR

Taltz® is indicated for the treatment of pediatric patients 6 years of age or older with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Pediatric Psoriasis Patient Weight	Device Type	Dosing
If >50 kg (110 lbs)	Must select one: <input type="checkbox"/> Prefilled syringe (80 mg/mL) <input type="checkbox"/> Auto Injector (80 mg/mL)	<input type="checkbox"/> Starting Dose: 2 x 80 mg (160 mg total) by subcutaneous injection on Day 1 <input type="checkbox"/> Maintenance Dose: 1 x 80 mg by subcutaneous injection every 4 weeks (thereafter)
If 25 kg (55 lbs) or ≤50 kg (110 lbs)	Must use: Prefilled syringe (80 mg/mL)	<input type="checkbox"/> Starting Dose: 1 x 80 mg by subcutaneous injection on Day 1 <input type="checkbox"/> Maintenance Dose: 1 x 40 mg by subcutaneous injection every 4 weeks (thereafter)
If <25 kg (55 lbs)	Must use: Prefilled syringe (80 mg/mL)	<input type="checkbox"/> Starting Dose: 1 x 40 mg by subcutaneous injection on Day 1 <input type="checkbox"/> Maintenance Dose: 1 x 20 mg by subcutaneous injection every 4 weeks (thereafter)

For pediatric patients ≤50 kg (110 lbs), Taltz® must be administered by a healthcare professional.

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**

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.

