Lilly Cares Foundation Patient Assistance Program
PO Box 13185
La Jolla, CA 92039
Phone: 1-800-545-6962
Fax: 1-844-431-6650
www.lillycares.com

Lilly Cares Prescription FAX Form Emgality®

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.

☐ **Emgality® (galcanezumab-gnlm)** injection, for subcutaneous use

Please indicate patient's treatment plan by completing one of the below options:

Emgality® is indicated for the preventive treatment of migraine in adults.

Injection Device: (choose one): ☐ prefilled pen (120 mg/mL) or ☐ prefilled syringe (120 mg/mL)

Month 1 Loading Dose: ☐ 240 mg (2 x 120 mg) subcutaneous injection X 1 (Dispense 2 devices with No Refills)

followed by:

Monthly Maintenance Dose: ☐ 120 mg subcutaneous injection monthly (Dispense 1 device per month)

OR

Emgality® is indicated for the treatment of episodic cluster headache in adults.

Injection Device: ☐ prefilled syringe (100 mg/mL)

Monthly Dose: ☐ 300 mg subcutaneous at the start of a cluster cycle (administered as three consecutive injections of 100 mg each) and then every month as needed until the end of the cluster cycle (Dispense 3 devices per month)

Quantity to be dispensed: ☐ 4 month supply (max) ☐ 3 month supply ☐ 2 month supply ☐ 1 month supply

Refills: #__________ 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): ______________________

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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