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

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 moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

For 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 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

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) : _____