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): _____