The Lilly Cares® Foundation Patient Assistance Program ("Lilly Cares")
Prescription FAX Form Taltz® (ixekizumab) injection for subcutaneous use

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Drug Allergies: _____

Other Medications: _____

Ship to Address (if different from patient address above, No P.O. Box or third-party vendor):

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

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 Neovance Specialty Pharmacy (NPI 1780811125) in your eRx software.

Taltz® Injection Device (choose one): ☐ Autoinjector (80mg only) or ☐ Prefilled Syringe

Please indicate ADULT 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

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

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)	□ 80 mg/mL Prefilled syringe □ 80 mg/mL Autoinjector	□ **Starting Dose:** 2 x 80 mg (160 mg total) by subcutaneous injection on Day 1 □ **Maintenance Dose:** 1 x 80 mg by subcutaneous injection every 4 weeks (thereafter)
If 25 kg (55 lbs) or ≤50 kg (110 lbs)	□ 80 mg/mL Prefilled syringe □ 40 mg/0.5 mL Prefilled syringe	□ **Starting Dose:** 1 x 80 mg by subcutaneous injection on Day 1 □ **Maintenance Dose**: 1 x 40 mg by subcutaneous injection every 4 weeks (thereafter)
If <25 kg (55 lbs)	□ 40 mg/0.5 mL Prefilled syringe □ 20 mg/0.25 mL Prefilled syringe	□ **Starting Dose:** 1 x 40 mg by subcutaneous injection on Day 1 □ **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 or a caregiver who has received training and demonstrated proper subcutaneous injection technique.

Quantity to be Dispensed: ☐ 4 months (max) ☐ 3 months ☐ 2 months ☐ 1 month **Refills:_____#** (up to one year of treatment)

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): _____

PP-AP-US-0679 04/2025