taltz together™
(ixekizumab) injection

Taltz Together™ Savings and Support Enrollment Form, and Prescription Information

OFFICE STAFF
- Please **FAX** the **FRONT AND BACK** of this form with prescriber and patient signature to **1-844-344-8108**
- Please call the Taltz Together program at **1-844-TALTZ-NOW (1-844-825-8966)** for any questions or concerns

1. Patient Information (Must complete to activate savings card)

Name (First, Last) ________________ ________________ DOB (MM/DD/YYYY) ________________

US or Puerto Rico Resident ☐ Yes ☐ No Gender ☐ M ☐ F Preferred Language ☐ English ☐ Spanish ☐ Other ________________

Address ________________ City ________________ State ______ ZIP Code ________

Phone* ________________ Email ________________

*By providing my mobile telephone number and signing this form, I agree to receive automated [and or prerecorded] calls and texts about the Taltz Together program and I understand that no purchase is necessary to receive these calls or texts. By signing below, I agree and certify that I am eighteen (18) years of age.

☐ **Yes, I am** ☐ **No, I am not Enrolled in a governmental program or have government insurance.** Examples include Medicaid, Medicare, Medicare Part D, TRICARE, and others.

☐ **I would like to request a Taltz Savings Card and agree to the Savings Card Terms and Conditions on page 2.**

☐ **I would like Taltz Together Support and agree to the Terms and Conditions on page 2.**
I have read and agree to the Patient HIPAA Authorization on the back of this form.

________________ ________________
SIGNATURE OF PATIENT **DATE (MM/DD/YYYY)**

2. Primary Prescription Information

☐ Copy of the policyholder's insurance card (front and back) is attached ☐ Complete the following insurance information **OR** ☐ No insurance coverage

Prescription Company ________________ Policyholder ________________ Prescription Company Phone ________________

Policy # ________________ Group # ________________ Rx BIN ________________ PCN ________________

3. Support Requested for This Patient

Select the **one** option below that your patient or office would like to receive

☐ **Benefits Investigation & Field Reimbursement Support** **OR** ☐ **Field Reimbursement Support Only**

Taltz Together will research the patient's insurance and in-network pharmacy options to help identify the lowest out-of-pocket cost available.

Name of Specialty Pharmacy ________________
Taltz Together and/or the Lilly Field Reimbursement Manager will work on the patient's behalf if access issues arise after the Taltz prescription is sent to the specialty pharmacy listed above.

Select additional patient support
☐ Injection Training
☐ Sharps Disposal Container

4. Prescriber Information

Name (First, Last) ________________ NPI # ________________

Practice Name ________________ Address ________________

City ________________ State ______ ZIP Code ________ Phone ________________ Fax ________________

Office Contact Name ________________ Office Contact Phone ________________

Office Contact Email ________________ Group Tax ID # ________________

5. Clinical Information

Primary Diagnosis/ICD-10 Codes (select all that apply) ☐ Plaque Psoriasis (ICD-10 Code: L40.0) ☐ Arthropathic Psoriasis (ICD-10 Code: L40.50)

Prior Treatment Failures, Contraindications, Intolerances, or Allergies (select all that apply) ☐ No previous biologic or systemic agent

☐ Phototherapy ☐ Methotrexate ☐ HUMIRA® ☐ Otezla® ☐ ENBREL® ☐ STELARA® ☐ COSENTYX® ☐ Other(s) ________________

6. Taltz Prescription Information

☐ Autoinjector (80 mg/mL)
OR
☐ Prefilled Syringe (80 mg/mL)

Dosing: Moderate to Severe Psoriasis with or without Psoriatic Arthritis	Quantity	Day Supply	Refills
☐ **Starting Dose:** 160 mg (2 x 80 mg) subcutaneous injections on Day 1, then begin first induction dose (1 x 80 mg) 2 weeks later (week 2)	3 pens/syringes	28	0
☐ **Induction Dose:** 1 x 80 mg subcutaneous injection every 2 weeks (weeks 4-10)	2 pens/syringes	28	1
☐ **Final Induction Dose:** 1 x 80 mg subcutaneous injection (week 12)	1 pen/syringe	28	0
☐ **Maintenance Dose:** 1 x 80 mg subcutaneous injection every 4 weeks (thereafter)	1 pen/syringe	28	______

OR

Dosing: Active Psoriatic Arthritis without Moderate to Severe Psoriasis	Quantity	Day Supply	Refills
☐ **Starting Dose:** 2 x 80 mg each (160 mg total) by subcutaneous injection on Day 1	2 pens/syringes	28	0
☐ **Maintenance Dose:** 1 x 80 mg by subcutaneous injection every 4 weeks (thereafter)	1 pen/syringe	28	______

Prescriber Signature

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to Eli Lilly and Company, its affiliates, agents, representatives, business partners, and service providers (together "Lilly") to help enable treatment for this patient; 3) The patient is aware of, has consented to, and has directed my disclosure of their information to Lilly so that Lilly may contact the patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the patient's therapy; 4) I will not seek reimbursement from any third party for the support Lilly provides; and 5) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements, and I appoint Lilly as my agent for the limited purpose of conveying this prescription to the dispensing pharmacy.

I understand that by signing this form, I am requesting support from Eli Lilly and Company for patients receiving Taltz pursuant to the approved indication.

PRESCRIBER MUST MANUALLY SIGN Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

________________ ________________ ________________
PRESCRIBER SIGNATURE (Dispense as written) **DATE (MM/DD/YYYY)** **May substitute/brand exchange permitted**

What to Know About Taltz Together Support

We created the Taltz Together program to give you personalized support while taking Taltz. Through this ongoing support, your Taltz Together team will serve as your dedicated partner. They can help you navigate through insurance processes, identify savings opportunities, and answer questions you may have about Taltz.

Taltz Together Ongoing Support Enrollment Consent

The Ongoing Support Offerings included in Taltz Together provide support after you've received your medication, like check-in calls to answer any questions you might have about Taltz. As part of your participation in the Ongoing Support Offerings, Eli Lilly and Company and Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "Lilly") may use, disclose, and/or transfer the personal information you supply to provide support related to your condition and treatment to administer the program.

Offerings include:

- Contacting you by email, mail, or telephone to provide personalized support such as informational and marketing materials
- Responding to customer support requests and/or questions about your treatment
- Requesting feedback on your experience with the related products, offerings, and programs, including market research
- Disclosing your enrollment and use of this support to your doctors and insurers
- Analyzing and/or measuring program performance for future enhancements
- Other opportunities and activities related to your condition and therapy that are not part of Taltz Together. These activities include opportunities to share your story and participate in studies about products and offerings

By checking the corresponding box on the first page under Section 3: Ongoing Support for Taltz, you consent to your enrollment in Taltz Together Ongoing Support as described in this Consent.

Patient HIPAA Authorization

Before Taltz Together can start helping you, Lilly may ask for some information about you and your health. This is known as your *Protected Health Information,* or *PHI*. By signing this form, you understand and agree that your PHI may be shared or used as explained below.

PHI includes information like:

- Your health insurance or benefits, including how much coverage you have
- All records about your treatment
- Anything that affects your health
- Whether you're staying on your medicine or treatment

If you agree, your PHI may be shared by:

- Your doctors and other healthcare providers
- Your healthcare plan or health insurance company
- Your pharmacy
- Others who might have your PHI

Your PHI is used in ways like these:

- To learn how much of your Lilly treatment is covered by your insurance
- To help you find other ways to afford your treatment
- To track your use of your Lilly treatment
- To share information with your healthcare provider
- To make sure that you receive high-quality services from the program
- To measure program performance and make program improvements
- Internal Lilly use of data to drive business decisions and metrics on hub performance
- Reports to our sales force regarding HCP use of hub services
- Conversations/messages to your HCP regarding trends and hub performance

Other things you should know about sharing and using your PHI:

- We only ask for and share the PHI that we need to provide the benefits you want. We do not ask for any PHI that we do not need, but we may receive some in the health records sent to us
- You don't have to give permission to share your PHI with Lilly to receive treatment from your healthcare providers, your prescription from your pharmacy, or benefits from your healthcare plan, but Taltz Together may not be able to help you without it
- After your PHI has been shared, it may no longer be covered by federal and state privacy laws (such as HIPAA), and it may be shared again
- Your permission to share and use your PHI lasts for 1 year, unless you change your mind before then. You can stop allowing your PHI to be shared at any time, but this will not affect information or disclosures shared before Lilly receives your request
- Your healthcare providers (such as pharmacies) may be paid by us in exchange for sharing your PHI and/or to perform certain services for you. They may use your information to provide services, such as contacting you about Lilly products

If you would like to opt out of the program or make changes to your enrollment:

- You can stop sharing your PHI with us or change what you share by calling us at **1-844-TALTZ-NOW** (1-844-658-6426) or by writing us at PO Box 12307, La Jolla, CA 92039

Savings Card Terms and Conditions

Eligibility Criteria: By using the Taltz Savings Card ("Card"), you attest that you meet the eligibility criteria and will comply with the Terms and Conditions described below:

Offer void where prohibited by law and subject to monthly and annual caps. **This offer is invalid for patients without commercial drug insurance or those whose prescription claims are eligible to be reimbursed, in whole or in part, by any governmental program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DOD, VA, TRICARE/CHAMPUS, or any state patient or pharmaceutical assistance program.** If you live in Massachusetts, the Card expires on the earlier of: (i) the expiration date of this card 12/31/2022; (ii) the date an AB-rated generic equivalent for Taltz becomes available; or (iii) June 30, 2019, absent a change in Massachusetts state law. If you live in California, the card expires on the earlier of: (i) the expiration date of this card 12/31/2022 or (ii) the date an FDA-approved therapeutic equivalent for Taltz or over-the-counter product with the same active ingredient becomes available. Available only in the US and Puerto Rico for residents of the US and Puerto Rico.

By accepting this offer, you agree that if you are required to do so under the terms of your insurance coverage for this prescription or are otherwise required to do so by law, you should notify your insurance carrier of your redemption of this Card. This offer is not valid with any other program, discount, discount card, incentive, or similar offer involving Taltz. It is prohibited for any person to sell, purchase, or trade; or to offer to sell, purchase or trade; or to counterfeit this Card. This offer may be terminated, rescinded, revoked or amended by Lilly USA, LLC, at any time without notice. Card activation required. This Card is not health insurance. This Card expires on 12/31/2022. Patients must first use their card by 12/31/2019 and are eligible for savings for up to 36 months of therapy. Subject to additional terms and conditions, which can be found at www.taltz.com.

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Lilly