FLEXCARE SPECIALTY SERVICES

Thank you for your referral for TALTZ

(for Dermatology indications).

REQUIRED DOCUMENTATION

Please send the following items to initiate the new prescription process:

- ☑ Manufacturer form (attached), complete with FlexCare Specialty Services identified as the preferred specialty pharmacy
- ☑ Patient Demographics
- ☑ Insurance Card
- ☑ Recent Clinicals & Labs
- ☑ Medication List
- ☑ Tried/Failed Therapies
- ☑ Negative TB Results

INSTRUCTIONS

1. Please send the completed forms to us for processing.
2. You may also send the completed forms to the manufacturer, if enrollment into the manufacturer's monitoring program is desired.

PHONE: 866-205-4239 | FAX: 855-222-2514
Email: referrals@flexcarespecialty.com | visit: flexcareinfusion.com/referrals

taltz together™ (ixekizumab) injection

PATIENT ENROLLMENT SECTION
Taltz® (ixekizumab) Dermatology

UPDATED 12/2022

OFFICE: Complete the entire form and submit pages 1-3 to Taltz Together™ via fax at 1-844-344-8108 or upload online at https://patientsupportnow.org and code: 8443448108. For assistance, call 1-844-TALTZ-NOW (1-844-825-8966), Monday-Friday 8am – 10pm ET.

Section 1: Patient Information

Patient Name (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

Address _____ **City** _____ **State** _____ **Zip** _____

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

Phone* _____ **Email** _____

☐ *By checking the box, I agree to receive automated marketing calls and texts from and on behalf of Eli Lilly and Company. I understand that I am not required to provide my number as a condition of receiving goods and services. Message and data rates may apply.

☐ By checking the box, I agree to be contacted to: provide feedback on my experience with the related products, services, and programs; to share my story; and, to participate in market and medical research studies about products and services.

Section 2: Insurance Information

Must select one of the following: ☐ **No Insurance Coverage** ☐ **Copy of Policyholder's Insurance Card (Front and Back) Is Attached** ☐ **Provide Information Below**

Primary Prescription Insurance Company _____

Insurance Company Phone # _____ **Cardholder Name** _____

Policy/ID _____ **Group #** _____

RX BIN _____ **PCN** _____

Section 3: Service Selection

Please select which options you would like to enroll in by checking the corresponding checkboxes below. By enrolling in any of these services below, you are agreeing to the Terms of Participation.

☐ **1. Taltz® Savings Card**

SAVINGS CARD ELIGIBILITY (must confirm the below statements in order to be eligible)

☐ I confirm that I am a resident of the United States or Puerto Rico who is 18 years of age

☐ I confirm that I am NOT enrolled in a government-funded prescription program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state or pharmaceutical assistance program

☐ **2. Injection Training**

☐ **3. Sharps Disposal Support**

TERMS OF PARTICIPATION:

Your healthcare provider has talked with you about using Taltz®, an Eli Lilly and Company medicine. Taltz Together™ offers personalized support to Patients at no charge and was created to help you have a positive experience as you get started with and use this medicine. By checking the corresponding optional boxes above, you consent to your enrollment in Taltz Together™. As part of your participation in Taltz Together™, you understand and authorize Lilly USA, LLC to retain and use your personal information for the purposes described in this form. 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 services related to your condition and treatment to administer the program. The Taltz Together™ Support team can contact you by email, mail or telephone to provide personalized services and information and materials directly related to your condition and therapy; responding to customer service requests and/or questions about your treatment; disclosing your enrollments and use of these services to your doctors and insurers; analyzing and/or measuring program performance and program effectiveness for future enhancements; and other activities related to your condition and therapy that are part of Taltz Together™. These activities include opportunities to share your story and participate in studies about products and services. To cancel your participation in the program, please contact us at 1-844-TALTZ-NOW (1-844-825-8966) Mon-Fri, 8am -10pm ET.

By using the Taltz Savings Card ("Card"), you attest that you meet the eligibility criteria, agree to, and will comply with the terms and conditions described below:

Offer good until 12/31/2025 or for up to 36 months from Patient qualification into the program, whichever comes first. Patients must have coverage for Taltz through their commercial drug insurance and a prescription consistent with FDA approved product labeling to pay as little as $5 for a 28-day supply of Taltz. Offer subject to a monthly cap of wholesale acquisition cost plus usual and customary pharmacy charges and a separate annual cap of $9,100. Patients must have commercial drug insurance and prescription consistent with FDA-approved product labeling to pay as little as $25 for a 28-day supply of Taltz. Participation in the $25 program requires submission of a prior authorization (PA). If coverage is denied, an appeal must be submitted prior to 5th month fill. A new PA and appeal or medical exception (ME) must be submitted every 12 months or as required by Lilly to verify coverage status and potential eligibility for the $5 program. Offer subject to a monthly cap and a separate annual cap. Monthly and annual caps are set at Lilly's absolute discretion and may be changed by Lilly with or without notice. If a patient's commercial drug insurance plan imposes additional requirements which limits or prevents the patient from receiving coverage, only allows partial coverage, or at Lilly's discretion determines the patient is effectively uninsured because such coverage does not provide a material level of financial assistance for the cost of a Taltz prescription, or does not apply Taltz Savings Card Program payments to satisfy the patient's co-payment, deductible, or coinsurance for Taltz, Lilly has the right to reduce or eliminate the payments provided by the Taltz Savings Card Program. Participation in the program requires a valid patient HIPAA authorization. Offer void where prohibited by law. Patient is responsible for any applicable taxes, fees, or amounts exceeding monthly or annual caps. **This offer is invalid for Patients without commercial drug insurance or whose prescription claims for Taltz 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.** This offer is not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. Available only in the US and Puerto Rico for residents of the US and Puerto Rico who are 18 years of age or older. 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 cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, 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 12/31/2025. Upon offer expiration, at Lilly's sole discretion you may be eligible to re-enroll by activating a new offer.

Lilly

taltz together™ (ixekizumab) injection

PATIENT HIPAA AUTHORIZATION

UPDATED 12/2022

OFFICE: Complete the entire form and submit pages 1-3 to Taltz Together™ via fax at 1-844-344-8108 or upload online at https://patientsupportnow.org and code: 8443448108. For assistance, call 1-844-TALTZ-NOW (1-844-825-8966), Monday-Friday 8am – 10pm ET.

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

PHI includes information like:

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

If you agree, your PHI may be shared by these entities (together "Health Care Entities"):

- Your doctors and other healthcare providers
- Your healthcare plan or health insurance company
- Clearinghouses or other agents
- Your pharmacy
- Others who might have your PHI on behalf of your healthcare providers, pharmacies and healthcare plans

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. Your PHI will be released to Eli Lilly and Company and Lilly USA, LLC and its affiliates, agents, representatives, and service providers (together "Lilly").
- 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 with others by Lilly
- Your signed permission to share and use your PHI lasts for 3 years from the date of your signature unless you are a resident of Maryland, Maine, or Montana, in which case the permission will last for 1 year from the date of your signature. In either case, you may revoke your permission before then by writing to PO Box 221349, Charlotte, NC 28222, which will preclude reliance on the authorization after the date your written revocation is received
- Your healthcare providers (such as pharmacies) may be paid by us in exchange for sharing your PHI. They may also be paid by us to use your PHI to provide services, such as contacting you about Lilly products
- **You can stop sharing your PHI with us or change what you share by calling us at 1-844-TALTZ-NOW (1-844-825-8966) or by writing us at PO Box 221349, Charlotte, NC 28222**
- **Your cancellation or revocation of this Authorization will be effective when your Health Care Entities receive notice of your cancellation or revocation, and will not apply to any information shared with Lilly by your Health Care Entities prior to the time those Health Care Entities receive notice**

By signing this form, I attest that I have read and agree to the Patient HIPAA Authorization. I understand I am entitled to a copy of this signed Authorization.

Signature of Patient _____ **Date Signed (MM/DD/YYYY)** _____

Printed Name of Patient _____ **Date of Birth (MM/DD/YYYY)** _____

Not signing this form will result in an incomplete submission and a delay in requested services

Lilly

taltz together™ (ixekizumab) injection

PRESCRIBER ENROLLMENT SECTION
Taltz® (ixekizumab) Dermatology

UPDATED 12/2022

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Section 4: Prescriber information

Name (First, Last) _____ **NPI #** _____

Practice Name _____ **Phone** _____ **Fax** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Office Contact Name _____ **Office Contact Phone** _____

Office Contact Email _____

Collaborating Physician _____ **NPI #** _____ **Group Tax ID** _____

Section 5: Diagnosis

Patient Name (First, MI, Last) _____ **DOB** (MM/DD/YYYY) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Diagnosis:

☐ Plaque Psoriasis (ICD-10 Code: L40.0)

☐ Plaque Psoriasis (ICD-10 Code: L40.0) with Psoriatic Arthritis (ICD-10 Code: L40.5)

☐ Psoriatic Arthritis (ICD-10 Code: L40.5)

Section 6: HCP Service Selection & Prescription

Benefits Investigation Support (select one choice)

☐ **Specialty Pharmacy Conducted Benefits Investigation**–Specialty Pharmacy where prescription was sent FlexCare Specialty Services
Specialty Pharmacy Phone Number (866) 205-4239

☐ **Lilly Conducted Benefits Investigation**–Taltz Together™ will research the Patient's insurance and in-network Specialty Pharmacy options to help identify the lowest out-of-pocket cost available for Taltz® and will forward the prescription to the Specialty Pharmacy that the Patient selects. A Taltz Together™ representative will help triage and troubleshoot access issues on the Patient's behalf. **IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION BELOW.**

Taltz® Dermatology Prescription — Fill out corresponding prescription below and sign at the bottom of page

Device Type (Select ONE)
Taltz® (ixekizumab) 80mg/mL 1mL inj

☐ Auto Injector ☐ Pre-Filled Syringe

You must select a Device Type and Dosing

Diagnosis	Taltz® Prescribing Information (PI) Adult Dosing	Quantity	Days Supply	Refills
Plaque Psoriasis **OR** Plaque Psoriasis with Psoriatic Arthritis	☐ **Starting Dose:** 160 mg (2 x 80 mg) subcutaneous injection 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 by subcutaneous injection every 4 weeks (thereafter)	1 pen/syringe	28	_____
Psoriatic Arthritis	☐ **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	_____

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

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

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, Lilly USA, LLC, their 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 purposes of conveying this prescription by facsimile only 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 an FDA approved indication. **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE.** Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.

_____ _____ _____

Dispense as written **May substitute/brand exchange permitted** **Date Signed (MM/DD/YYYY)**

Not signing this form will result in an incomplete submission and a delay in requested services

Lilly