Lilly Support Services™

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Taltz® (ixekizumab) Pediatric ENROLLMENT FORM

PUBLISHED 11/2025

HAVE YOUR PATIENT SCAN to add Lilly Support Services™ for Taltz® to their phone contacts

To prevent delays in getting your Patient started, please complete in full. Items with † are required to complete enrollment. Upon completion, submit pages 1-4 via fax to 1-844-344-8108.

THIS PAGE MUST BE SUBMITTED

SECTION 1: PATIENT AND AUTHORIZED REPRESENTATIVE INFORMATION

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

Gender† ☐ M ☐ F **Patient State of Residence** _____

Authorized Representative Name† (First, MI, Last) _____ **DOB† (MM/DD/YYYY)** _____

Relationship to Patient _____

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

Gender† ☐ M ☐ F **Preferred Language** ☐ English ☐ Spanish ☐ Other _____ **Email** _____

Phone†* (000-000-0000) _____ **Preferred Contact:** ☐ Phone Call ☐ Text ☐ Email

By providing Lilly with your cell phone number and email address with the consent below, you can conveniently receive updates and status changes about your enrollment.

☐ ***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.

HIPAA AUTHORIZATION NEEDED: AUTHORIZED REPRESENTATIVE SIGNATURE REQUIRED AT BOTTOM OF PAGE 4 FOR ENROLLMENT

SECTION 2: INSURANCE INFORMATION

Must select one of the following†:

☐ **Provide Information Below (if this box is checked, then the information below is required)**

☐ **Copy of Policyholder's Insurance Card (Front and Back) Is Attached**

☐ **No Insurance Coverage**

Primary Prescription Insurance Company _____

Insurance Phone # (000-000-0000) _____ **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 and consenting to the collection of your information, inclusive of health information as described in our Privacy Notice.

☐ **1. Savings Card: Provides eligible, commercially-insured Patients with options to save on treatment costs**

SAVINGS CARD ELIGIBILITY (must confirm the below statements)

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

☐ I confirm that I have reviewed and agree to the Terms and Conditions on Page 5 and attest that I am eligible to participate in this program

☐ **2. Sharps Disposal: Provides a free Sharps disposal container for Lilly injectable devices**

☐ **3. Injection Training: Provides step-by-step education from a Registered Nurse on how to appropriately self-inject the medication**

TERMS OF PARTICIPATION AND PROGRAM DISCLOSURES:

Your healthcare provider has talked with you about using Taltz®, an Eli Lilly and Company medicine. Lilly Support Services™ for Taltz® 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 into Lilly Support Services™ for Taltz®. As part of your participation in Lilly Support Services™ for Taltz®, 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, 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 Lilly Support Services™ for Taltz® 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 Lilly Support Services™ for Taltz®. Your personal information, including information that may be related to your health, is needed to fulfill your request. To cancel your participation in the program, please contact us at 1-800-LillyRx (1-800-545-5979) Monday-Friday, 8am -10pm ET. For information about Lilly's privacy practices, please see our Privacy Statement at https://privacynotice.lilly.com and the Consumer Health Privacy Notice at https://www.lillyhub.com/legal/lillyusa/CHPN.html.

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For assistance, call 1-800-LillyRx (1-800-545-5979), Monday-Friday, 8am-10pm ET.

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SECTION 4: PRESCRIBER INFORMATION

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

Practice Name† _____ **Office Phone**† **(000-000-0000)** _____

Office Fax† **(000-000-0000)** _____ **Office Address**† _____

Office City† _____ **Office State**† _____ **Office Zip**† _____ **Group Tax ID** _____

Office Contact Name _____ **Office Contact Phone (000-000-0000)** _____

Office Contact Email _____

Collaborating Physician _____ **NPI** _____

SECTION 5: DIAGNOSIS

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

Patient Address† _____ **Patient City**† _____ **Patient State**† _____ **Patient Zip**† _____

Diagnosis†:

☐ **L40.0 Plaque Psoriasis**

SECTION 6: HCP SERVICE SELECTION & PRESCRIPTION

Benefits Investigation Support (SELECT ONE)†

☐ **Lilly Conducted Benefits Investigation–IF CHECKED, MUST FILL OUT PRESCRIPTION SECTION BELOW.**
Lilly Support Services™ for Taltz® 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 Lilly Support Services™ for Taltz® representative will help triage and troubleshoot access issues on the Patient's behalf.

OR

☐ **Specialty Pharmacy Conducted Benefits Investigation–IF CHECKED, MUST COMPLETE FIELDS BELOW.**
Specialty Pharmacy where prescription was sent
_____

Specialty Pharmacy Phone Number (000-000-0000)
_____

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

Dosing for Plaque Psoriasis (ICD-10 L40.0), based on Patient weight

WEIGHT	DEVICE TYPE	DOSING	QUANTITY	DAY SUPPLY	REFILLS
If > 50 kg (110 lbs)	**Select ONE:** ☐ Prefilled syringe (80 mg/mL) 1mL inj ☐ Auto Injector (80 mg/mL) 1mL inj	☐ **Starting Dose:** 2 x 80 mg each (160 mg total) subcutaneous injection on Day 1 ☐ **Maintenance Dose:** 1 x 80 mg subcutaneous injection every 4 weeks (thereafter)	2 pens/syringes 1 pen/syringe	28 28	0 (1-11) _____
If 25 kg (55 lbs) to 50 kg (110lbs)	Prefilled syringe (80 mg/mL) 1mL inj Prefilled syringe (40 mg/0.5 mL) 0.5 mL inj	☐ **Starting Dose:** 1 x 80 mg subcutaneous injection Day 1 ☐ **Maintenance Dose:** 1 x 40 mg subcutaneous injection every 4 weeks (thereafter)	1 syringe 1 syringe	28 28	0 (1-11) _____
If < 25 kg (55 lbs)	Prefilled syringe (40 mg/0.5 mL) 0.5 mL inj Prefilled syringe (20 mg/0.25 mL) 0.25 mL inj	☐ **Starting Dose:** 1 x 40 mg subcutaneous injection Day 1 ☐ **Maintenance Dose:** 1 x 20 mg subcutaneous injection every 4 weeks (thereafter)	1 syringe 1 syringe	28 28	0 (1-11) _____

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

☐ Phototherapy ☐ ENBREL® ☐ STELARA® ☐ 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.

☐ By checking this box, I confirm that the Patient has provided express consent to be contacted by automated text messaging from Eli Lilly and Company, and parties working on their behalf, to complete enrollment in the Patient Support Program.

_____ _____ _____

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

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HIPAA AUTHORIZATION

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You have selected Eli Lilly and Company ("Lilly") to coordinate certain services related to your health and to provide information related to your health (Lilly's "Programs and Services"). In order for Lilly to offer the Programs and Services, Lilly may need to obtain or exchange your protected health information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") from your Health Care Entities (as defined below). PHI can be inclusive of "sensitive data" as defined by applicable U.S. privacy laws. After your PHI has been released to Lilly, it is no longer covered by HIPAA. By signing this form, you understand and authorize your Health Care Entities to share your PHI with Lilly and use as explained below.

PHI includes the following individually identifiable information:

- Information about your health insurance or benefits, including how much coverage you have
- All relevant records about your treatment, including medication histories and prescriptions
- Information about your payment for treatment, including any insurance coverage
- Whether you're staying on your medicine or treatment

If you agree, your PHI may be collected from and 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

How Your PHI Will Be Used

Your PHI will be used to enroll you in, provide you with, and operate and administer the Programs and Services, consistent with Lilly's Privacy Statement and Consumer Health Privacy Notice, including to:

- understand how much of your Lilly treatment is covered by your insurance
- help you find ways to afford such treatment
- track the shipment, receipt, and use of your Lilly treatment and Programs and Services
- share information with your Health Care Entities and communicate with them regarding Lilly Programs and Services
- contact you about Lilly Programs and Services related to your health needs
- measure Lilly Programs and Services' performance in order to make improvements and drive business decisions and metrics
- de-identify your data for analytics including reports about Health Care Entities' use of Lilly Programs and Services.

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Other things you should know about how we may use and share your PHI:
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 Lilly and its wholly owned subsidiaries ("Lilly" or "we") and/or entities or persons that work on behalf of, or in partnership with, Lilly but are not Lilly employees ("Third Parties").

- You don't have to give permission to share your PHI with Lilly to receive treatment from your Health Care Entities, your prescription from your pharmacy, or benefits from your healthcare plan, but Lilly Programs and Services may not be able to help you without your Authorization.
- Your Health Care Entities may receive compensation from 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.
- Your signed authorization to share and use your PHI lasts for the duration of your participation in Lilly Programs and Services from the date of your signature or earlier as required by state law. In any case, you may revoke this Authorization for Lilly Programs and Services and you may request to obtain PHI from your Health Care Entities at any time by writing to PO Box 221349, Charlotte, NC 28222. Your revocation of this Authorization will not have any effect on any uses or disclosures of your PHI that occurred prior to Lilly's receipt of your revocation.
- **Your 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 prior to receipt of the notice.**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my Health Care Entities to disclose my PHI and sensitive data for the purposes as described in this HIPAA Authorization. This HIPAA Authorization replaces any prior HIPAA Authorizations that I may have provided at a specific program level.

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

SIGN and DATE

Signature of Authorized Representative† _____

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

Printed Name of Authorized Representative _____

Signature Date† **(MM/DD/YYYY)** _____

Authorized Representative Date of Birth (MM/DD/YYYY) _____

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SAVINGS CARD TERMS AND CONDITIONS

By enrolling in the Taltz Savings Card Program ("Program") and 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:

Card Eligibility:

(1.) You have been prescribed Taltz® (ixekizumab) for an approved use consistent with FDA approved product labeling;
(2.) You are enrolled in a commercial drug insurance plan;
(3.) **You are not enrolled in any state, federal, or government funded healthcare program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medicare Advantage, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state prescription drug assistance program;**
(4.) You are a resident of the United States or Puerto Rico; and
(5.) You are 18 years of age or older.

Card Terms and Conditions:

For patients with commercial drug insurance coverage for Taltz: You must have commercial drug insurance that covers Taltz and a prescription for an approved use consistent with FDA-approved product labeling to pay as little as $5 for a 1-month prescription fill of Taltz. Month is defined as 28-days and up to 3 pens. Card must be first used by no later than 12/31/2026. Card savings are subject to a maximum monthly savings of wholesale acquisition cost plus usual and customary pharmacy charges and a separate maximum annual savings of up to $10,600 per calendar year. Card may be used for a maximum of up to 14 prescription fills per calendar year, subject to the previously stated maximum monthly and annual savings limit. Except where prohibited by applicable state law, Card monthly and annual savings are reduced if Lilly identifies that you are enrolled in a plan or program, sometimes called a maximizer plan, that adjusts your cost sharing amount to be equal to or include some portion of the savings provided by the Card and attempts to prevent the savings from this Card from being applied to your out-of-pocket costs, including but not limited to copayments, coinsurances, and deductibles ("Maximizer"). If the Program identifies you are enrolled in a Maximizer, Card savings are reduced to a maximum monthly savings of up to $25 and a separate maximum annual savings of up to $350 per calendar year. If you have reason to believe that the Program erroneously identified enrollment in a Maximizer, please call the Taltz Savings Card Program at 1-800-LillyRx (1-800-545-5979). Participation in the Program requires a valid patient HIPAA authorization upon enrollment into the Program. Subject to Lilly USA, LLC's right to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2028 or 24 months after you first use the Card, whichever comes first.

For patients with commercial drug insurance who do not have coverage for Taltz: You must have commercial drug insurance that does not cover Taltz and a prescription for an approved use consistent with FDA-approved product labeling to pay as little as $25 for a 1-month supply of Taltz. Month is defined as 28-days and up to 3 pens. Card savings are subject to a maximum monthly savings of wholesale acquisition cost plus usual and customary pharmacy charges, up to a maximum of up to 14 prescription fills per calendar year. Card must be first used by no later than 12/31/2026. Participation in the Program requires submission of a prior authorization (PA) prior to the first prescription fill. If coverage is denied, an appeal must be submitted prior to 5th month prescription fill. To remain eligible for the Program, a new PA, appeal, or medical exception must be submitted prior to the 13th prescription fill and as required by Lilly at its sole discretion. Participation in the Program requires a valid patient HIPAA authorization to remain in the Program. Subject to Lilly USA, LLC's right to terminate, rescind, revoke, or amend Card eligibility criteria and/or Card terms and conditions, which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2028 or 24 months after you first use the Card, whichever comes first.

Additional Program Terms and Conditions

If you have an insurance plan that is participating in an alternate funding program ("AFP") that requires you to apply to the Taltz Savings Card Program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of Taltz, you are not eligible for and are prohibited from using the Taltz Savings Card Program. AFPs include programs where coverage, reimbursement, or patient out of pocket costs for a product in some way vary based on the availability of a manufacturer co-pay program. AFPs may modify, delay, deny, restrict, or withhold insurance benefits or coverage from patients, or exclude Lilly products from coverage contingent upon a member's use of Taltz Savings Card Program. You agree to inform Taltz Savings Card Program if you are or become a member of such an alternative funding program. You are responsible for any applicable taxes, fees, and any amount that exceeds the applicable monthly or annual maximum Card savings. Monthly and annual maximum savings are set at Lilly's sole and absolute discretion and may be changed with or without notice at any time for any reason. At its sole discretion and with or without notice, Lilly may reduce, eliminate, or otherwise modify the Card savings for any reason, including but not limited to if your commercial drug insurance plan imposes additional requirements which limits or prevents you from receiving coverage for Taltz, only allows partial coverage for Taltz, removes coverage for Taltz and requires you to utilize the Card, does not provide a material level of financial assistance for the cost of Taltz, or does not apply Card payments to satisfy your co-payment, deductible, or coinsurance for Taltz. Card savings are not valid for: Massachusetts residents if an AB-rated generic equivalent is available; California residents if an FDA-approved therapeutic equivalent is available. You must meet the Card eligibility criteria, terms and conditions every time you use the Card. If at any time you begin receiving drug coverage under any state, federal, or government funded healthcare program, you understand that you will no longer be eligible for the Taltz Savings Card and agree to call the Taltz Savings Card Program at 1-800-LillyRx (1-800-545-5979) to stop participation. Card activation is required. You may not seek reimbursement from your health insurance, any third party, or any health savings, flexible spending, or other healthcare reimbursement accounts, for any amount of the savings received through the Card. By utilizing the Card, 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 will notify your Insurance Carrier of your redemption of the Card. Card savings cannot be combined or utilized with any other program, discount, discount card, cash discount card, coupon, incentive, or similar offer involving Taltz. You agree that this Card savings is intended solely for the benefit of you, the patient, and that the Card benefits are non-transferable. It is prohibited for any person to sell, purchase, or trade; or to offer to sell, purchase, or trade, or to counterfeit the Card. **THIS CARD IS NOT INSURANCE**. Lilly has the sole right to interpret and apply Card eligibility criteria, and terms and conditions. Card eligibility, and terms and conditions may be terminated, rescinded, revoked, or amended by Lilly at any time without notice and for any reason. Lilly's sole discretion to terminate, rescind, revoke, or amend Card eligibility and/or Card terms and conditions includes the right to terminate any individual Card if Lilly determines, in its sole discretion, that a patient does not satisfy the Card's eligibility criteria or is using or has attempted to use the Card inconsistently with these terms and conditions. Eligibility criteria, and terms and conditions for the Taltz Savings Card Program may change from time to time; the most current version can be found at https://www.taltz.lilly.com/savings-support. You may be required to obtain a new Card, including if any Card terms and conditions have been terminated, rescinded, revoked, or amended by Lilly. Card void where prohibited by law. Subject to Lilly's right to terminate, rescind, revoke or amend Card eligibility criteria and/or Card terms and conditions, which may occur at Lilly's sole discretion, without notice, and for any reason. Card expires and savings end on 12/31/2028 or 24 months after you first use the Card, whichever comes first.

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