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Taltz Together Pediatric Savings and Support Enrollment Form

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Please complete and fax this form to **1-844-344-8108**

If you have any questions, please call Taltz Together™ at 1-844-TALTZ-NOW (1-844-825-8966), Monday-Friday 8am – 10pm EST

By enrolling in the Taltz Together™ program, Patients may receive various forms of support and information to help access Taltz®, which may include the following:

- Benefits Investigation Support
- Copay Savings and Other Financial Support
- Field Reimbursement Support
- Ongoing Support
- Sharps Disposal

In order to process the requested services, Taltz Together will require 2 Authorized Representative signatures and 1 Prescriber signature. Not signing this form will result in an incomplete submission and a delay in requested services.

Patient Enrollment Checklist:

Page 2

- ☐ Complete all sections in the Patient Enrollment section
- ☐ Document prescription insurance information or provide copies of prescription insurance card(s)
- ☐ Select optional Taltz Together services that you would like to receive

➔ **Be sure to sign and date where "Signature of Authorized Representative" is located**

Page 3

➔ **Read and sign Patient HIPAA Authorization**

Page 5-7

- ☐ Read and acknowledge the consent, terms and conditions, and privacy notice on remaining pages

Prescriber Enrollment Checklist:

Page 4

- ☐ Complete all sections in the Prescriber Enrollment section
- ☐ If the Patient requires in-office administration outside of the Prescriber's office, document the Administering Provider
- ☐ Complete the prescription section, including: device type, primary diagnosis, and dosing
- ☐ Document Prior Treatment Failures, Contraindications, Intolerances, or Allergies
- ☐ Select Benefits Investigation and Field Reimbursement Support OR Field Reimbursement Support Only
  - *If selecting Field Reimbursement Support Only, indicate which specialty pharmacy the prescription should be sent to*

➔ **Manually sign and date the form**

Complete and fax this form to **1-844-344-8108**

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PATIENT ENROLLMENT SECTION Taltz Together™ Pediatric

OFFICE: Please fax to 1-844-344-8108

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Authorized Representative: Fill out both the Patient section and the Authorized Representative section and sign on behalf of the Pediatric Patient

Patient

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

Gender ☐ M ☐ F

Authorized Representative

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

Relationship to Patient _____

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

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

Phone* _____ **Email** _____

*By providing my telephone number and signing this form, 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 purchase. Message and data rates may apply.

By signing this form as the Authorized Representative, I represent that I will serve as the Authorized Representative for the Pediatric Patient.

Signature of Authorized Representative _____ **Date (MM/DD/YYYY)** _____

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

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** _____

☐ No ☐ Yes **Do you use government insurance to fill your prescriptions? 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 5

☐ I would like **Taltz Together Ongoing Support** and agree to the Optional Taltz Together Ongoing Support Enrollment Consent on page 6

☐ I would like **Sharps Disposal Support** and agree to the Optional Taltz Together Ongoing Support Enrollment Consent on page 6

I understand I am enrolling in Taltz Together to help facilitate access to my prescribed medication. By checking the corresponding optional boxes above, I consent to my enrollment in the additional Taltz Together services as described in the Consent on page 6. To cancel your participation in the program, please contact us at **1-844-TALTZ NOW (1-844-825-8966).**

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PATIENT HIPAA AUTHORIZATION

OFFICE: Please fax to 1-844-344-8108

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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 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
- Anything that affects your health

If you agree, your PHI may be shared by:

- 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

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
- 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 12307, La Jolla, CA 92039, 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

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 (1-844-825-8966)** or by writing us at PO Box 12307, La Jolla, CA 92039

I have read and agree to the Patient HIPAA Authorization. By signing this Authorization, I represent that I will serve as the Authorized Representative for the Pediatric Patient.

Signature of Authorized Representative _____ **Date (MM/DD/YYYY)** _____

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

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PRESCRIBER ENROLLMENT SECTION Taltz Together™ Pediatric

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Prescriber

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

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

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

Group Tax ID _____ **Office Contact Name** _____ **Office Contact Phone** _____

Collaborating Physician _____ **NPI #** _____

Patient

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

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

Dosing for Plaque Psoriasis (ICD-10 L40.0:), based on patient weight		***Valid prescription includes: Device Type, Primary Diagnosis, and Dosing***			
Weight	**Device Type**	**Dosing**	**Quantity**	**Days Supply**	**Refills**
If > 50kg (110 lbs)	**Must select one:** ☐ Prefilled syringe (80 mg/mL) ☐ Auto Injector (80 mg/mL)	☐ **Starting Dose:** 2 x 80 mg each (160 mg total) by subcutaneous injection on Day 1 ☐ **Maintenance Dose:** 1 x 80 mg by subcutaneous injection every 4 weeks (thereafter)	2 pens/ syringes 1 pen/ syringe	28 28	0 _____
If 25 kg (55 lbs) to < 50 kg (110 lbs)	**Must use:** Prefilled syringe (80 mg/mL)	☐ **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)	1 syringe 1 syringe	28 28	0 _____
If < 25 kg (55 lbs)	**Must use:** Prefilled syringe (80 mg/mL)	☐ **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)	1 syringe 1 syringe	28 28	0 _____

Fill out the below if the patient weight is < 50 kg

Product to be shipped to: ☐ Prescriber's Office ☐ Administering Provider's Office **(fill out information below)** ☐ Patient

Administering Provider

Name (First, Last) _____

Office/Hospital/Other Name _____

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

Phone _____ **Fax** _____

Taltz doses of 20 mg or 40 mg must be prepared and administered by a qualified Healthcare Provider using aseptic technique

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

☐ Phototherapy ☐ ENBREL® ☐ STELARA® ☐ Other(s) _____

OR

☐ **Benefits Investigation and Field Reimbursement Support**–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 ABOVE.**

☐ **Field Reimbursement Support Only**–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 a specialty pharmacy. **IF CHECKED, MUST FILL OUT THE SPECIALTY PHARMACY LINE BELOW.**

Specialty pharmacy or institution where prescription was sent _____

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 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 (MM/DD/YYYY)**

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SAVINGS CARD TERMS AND CONDITIONS

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Terms and Conditions:

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 for up to 36 months from patient qualification into the program or until 12/31/2023, whichever comes first, provided patient continues to meet program terms and conditions. Patients must first use their card by 12/31/2020. Patient must have coverage for Taltz with their commercial drug insurance to pay as little as $5 monthly for a 28-day supply of Taltz, subject to a monthly cap of wholesale acquisition cost plus usual and customary pharmacy charges and a separate $16,000 maximum annual cap. Patient must have commercial drug insurance and prescription consistent with FDA approved product labeling to pay as little as $25 monthly for a 28-day supply of Taltz, subject to a monthly cap of wholesale acquisition cost plus usual and customary pharmacy charges. Continued participation in the $25 program requires submission of a prior authorization (PA) before the 2nd month fill and, 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 to verify coverage status and potential eligibility for the $5 program. Participation in the program requires a valid patient HIPAA authorization. Patient is responsible for any applicable taxes, fees, or amounts exceeding monthly or annual caps.

Offer void where prohibited by law. **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 12/31/2023; (ii) the date an AB-rated generic equivalent for Taltz becomes available; or (iii) 12/31/2020, 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 12/31/2023 or (ii) the date an FDA-approved therapeutically equivalent for Taltz or over-the-counter product with the same active ingredients 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 cannot be combined with any other program, discount, discount card, cash 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. This Card is not health insurance. Card activation is required. This Card expires on 12/31/2023.

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What to Know About Taltz Together Ongoing Support Program:

Your healthcare provider has talked with you about using Taltz, an Eli Lilly and Company medicine. Taltz Together was created to help you have a positive experience as you get started with and use this medicine. Taltz Together offers personalized support to Patients at no charge.

OPTIONAL TALTZ TOGETHER ONGOING SUPPORT ENROLLMENT CONSENT

Ongoing Support Enrollment Consent:

The Ongoing Support Services 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 Services, 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.

Services include:

Contacting you by email, mail or telephone to provide personalized services, delivered by your Taltz Together Support team, such as information and marketing materials; responding to customer service requests and/or questions about your treatment; requesting feedback on your experience with the related products, services, and programs, including market research and medical research; disclosing your enrollment 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 not 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 EST.

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Privacy Notice:

We may use and save your personal information to meet legal or regulatory obligations that are in the legitimate interest of Lilly, to fulfill legitimate and lawful business purposes in accordance with Lilly's record retention policies and applicable laws and regulations, and to respond to lawful requests by public authorities, including to comply with national security or law enforcement requests.

Your information may be combined with other information that you have previously provided or that Lilly has received. We do not sell personal information.

We may transmit personal information about you to other Lilly affiliates worldwide. These affiliates may in turn transmit personal information about you to other Lilly affiliates. Some of Lilly's affiliates may be located in countries that do not ensure the same level of data protection. Nevertheless, all of Lilly's affiliates are required to treat personal information in a manner consistent with this notice. To obtain additional information about Lilly's privacy practices, including the basis for transfers and safeguards that Lilly has in place for cross-border transfers of personal information, please contact us at privacy@lilly.com or visit https://www.lilly.com/privacy.

We provide reasonable physical, electronic and procedural safeguards to protect information we work with and maintain. We limit access to your information to authorized employees, agents, contractors, vendors, subsidiaries, and business partners, or others who need such access to information to carry out their assigned roles and responsibilities on behalf of Lilly. Please be aware, although we try to protect the information we work with and maintain, no security system can prevent all potential security breaches.

Upon verification, you have the right to request information from us regarding how your personal information is being used and with whom that information is being shared. You also have the right to request to see and get a copy of the personal information that we have about you, request its correction or request its erasure/deletion.

There may be exceptions that apply to your request.

In limited circumstances, you may have the right to have your information transmitted to another entity or person in a machine-readable format.

You will not be discriminated against for exercising any of your rights.

To exercise your rights, you or your authorized representative may submit a request by contacting us using one of the methods listed below.

You may make any of the above requests by contacting us at: The Lilly Answers Center, Lilly USA, LLC, Lilly Corporate Center, Indianapolis, IN 46285 or by calling 1-800-545-5979.

If you wish to raise a complaint on how we have handled your personal information, you can contact the Global Privacy Office and Data Protection Officer at privacy@lilly.com who will investigate the matter.

If you are not satisfied with our response or have any concerns about how your data is being processed, you can register a complaint with a relevant regulatory authority (e.g. a Data Protection Authority (DPA) or Attorney General).

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Lilly