LillyPlus®

Taltz Patient Support Program **Enrolment form**

Fax: 1-844-344-3546
Email: Support@LillyPlus.ca
Program Phone: 1-877-219-8908

Patient Information

Last Name	**First Name**	
Phone number (please include area code) ( ) –	Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F
Address		
City	Province	Postal Code
Email (optional)		
☐ I authorize the program to leave a message	Language Preference ☐ E ☐ F ☐ Other: _____	

Assessment Details

For adult and pediatric moderate-to-severe plaque psoriasis

BSA (%) _____ PASI _____

DLQI _____ CDLQI _____

☐ Face ☐ Feet ☐ Hands ☐ Genitals

Select therapies taken by patient and indicate reason for stopping if applicable:
(IR=inadequate response, IN= intolerance, CI=contraindication)

	IR	IN	CI
☐ Methotrexate	☐	☐	☐
☐ Acitretin	☐	☐	☐
☐ Cyclosporine	☐	☐	☐
☐ Phototherapy	☐	☐	☐

For all diagnoses: other details, if applicable (eg. previous biologics)

For psoriatic arthritis

Radiographic Evidence? ☐ Yes ☐ No

Active joints (#) ____ HAQ _____

Swollen joints (#) ____ CRP _____

Tender joints (#) ____ BASDAI _____

Select therapies taken by patient and indicate reason for stopping if applicable:
(IR=inadequate response, IN= intolerance, CI=contraindication)

	IR	IN	CI
☐ Methotrexate	☐	☐	☐
☐ Leflunomide	☐	☐	☐
☐ Sulfasalazine	☐	☐	☐

For axial spondyloarthritis

Radiographic Evidence? ☐ Yes ☐ No

HAQ _____ BASDAI _____

NSAIDs tried and failed (#) _____
(include names, dose, and duration for each)

Other reimbursement criteria for coverage
(eg. VAS, BASFI, low back pain > 3 months)

Patient Consent

(If this cannot be obtained, please see verbal consent checkbox on the bottom right of this form)

PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND PATIENT CONSENT AND PRIVACY INFORMATION ON REVERSE OF THIS FORM.

I have read and understand the patient consent text and agree to the collection, use, and disclosure of my personal information in accordance with these terms.

Signature X

Patient/Legal Representative Name	Relationship to Patient	Date (MM/DD/YYYY)

Office Information

(Office address stamp can be used)

Prescribing Physician Name		
Address		
City	Province	Postal Code
Office Phone	Fax	
Email (optional)		
Clinic Contact (if not physician)	Preferred method of contact ☐ Phone ☐ Fax ☐ Email	

Medical Directive

I approve to start Taltz at this time

☐ Yes ☐ No. Pending test results ☐ No (Other, please specify below)

Rx Taltz (ixekizumab)

Device ☐ Autoinjector ☐ Prefilled syringe

Please select **diagnosis**, dosing, and duration as appropriate
For pediatric patients 6 to less than 18 years of age please complete page 2

☐ **Adult Moderate-to-Severe Plaque Psoriasis (PsO)**

- ☐ Starting dose: 160mg at week 0
- ☐ Induction dose: 80mg at weeks 2, 4, 6, 8, 10, 12
- ☐ Maintenance dosing: 80mg every 4 weeks for ____ **months**

☐ **Psoriatic Arthritis (PsA)***

- ☐ Starting dose: 160mg at week 0
- ☐ Maintenance dosing: 80mg every 4 weeks for ____ **months**

* For PsA patients with coexistent moderate-to-severe PsO, use dosing regimen for PsO. For PsA patients with coexistent mild PsO, use dosing regimen for PsA.

☐ **Axial Spondyloarthritis**

- ☐ 80mg every 4 weeks for ____ **months**
- ☐ For TNFi-experienced ankylosing spondylitis patients: optional starting dose 160 mg at week 0 followed by 80 mg every 4 weeks for ____ **months**

Physician Acknowledgment and Prescription

The use of Taltz for this patient is based on my clinical decision-making. I have reviewed the Taltz product monograph and informed the patient (or their legal representative) about the potential benefits and risks associated with its use.

PLEASE ENSURE YOU HAVE READ AND FULLY UNDERSTAND PHYSICIAN CONSENT ON THE REVERSE OF THIS FORM.
I have read and understand the physician consent text and agree to the collection, use, and disclosure of my information in accordance with these terms.

Signature

College License #	Date (MM/DD/YYYY)

☐ **If patient signature was not obtained** in Patient Consent section, check here as your representation of receiving verbal consent from the patient.

taltz® (ixekizumab)

PP-IX-CA-0271

INNOVATIVE MEDICINES CANADA

Lilly

Rx Taltz Moderate-to-Severe Plaque Psoriasis in Pediatric Patients 6 to less than 18 Years of Age

Patient Information

First name	Last name		
Date of birth (MM/DD/YYYY)	Phone #		
Address	City	Province	Postal Code

Physician Signature

College License # | Date (MM/DD/YYYY)

Dosing and Required Supplies

Patients Weight	Starting Dose (at week 0)	Maintenance dosing	Supplies Required:
☐ **>50 kg**	160 mg	80 mg every 4 weeks for _____ months:	☐ TALTZ Prefilled syringe ☐ TALTZ Autoinjector
☐ **25-50 kg**	80 mg	40 mg every 4 weeks for _____ months:	☐ TALTZ 80 mg/1 mL Prefilled syringe • 0.5 mL or 1 mL disposable syringe and Sterile needle for withdrawal • 27-gauge sterile needle for administration • Sterile clear glass vial
☐ **<25 kg**	40 mg	20 mg every 4 weeks for _____ months:	

*TALTZ doses of 20 mg or 40 mg must be prepared and administered by a qualified healthcare professional. Use only the commercial TALTZ 80 mg/1 mL prefilled syringe when preparing the prescribed 20 mg and 40 mg pediatric dose

PATIENT CONSENT AND PRIVACY

The words "you" and "your" on this page refer to the patient, or as appropriate, the patient's parent or legal representative enrolling in the LillyPlus Patient Support Program (the "Program") on the patient's behalf. The word "representative" means employee, agent, or contractor and "Lilly" refers to Eli Lilly Canada Inc.

Your information will be collected, used and stored as described below and in accordance with Lilly's Privacy Statement. A copy of our Privacy Statement is available upon request by contacting: Chief Privacy Officer, Eli Lilly Canada Inc. Exchange Tower 130 King St. W., Suite 900 P.O. Box 73 Toronto ON M5X 1B1. For further information please call 1-888-545-5972.

Personal Information: Collection, Use, and Storage
To participate in the Program, you may be asked to provide personal information to representatives of Lilly or their third-party patient support program providers, including:

- contact information
- personal health information
- information related to insurance coverage
- financial information

This information will be collected, used, and disclosed by Lilly or their third-party patient support program providers to provide the Program services and may be shared with:

- Lilly affiliates
- Representatives of Lilly and their third-party patient support program providers who have agreed abide by Lilly's privacy policies.
- Your public and private insurers.
- Your healthcare provider(s), who may share your information with your insurers

All personal information collected as part of the Program will be:

- Maintained in accordance with applicable legislation, regulations, and guidelines and in accordance with Lilly's Privacy Statement.
- Protected by adequate physical, administrative, and technical safeguards against loss or theft, and against unauthorized consultation, communication, copying, use or alteration. These safeguards will apply regardless of the format in which your information is stored.
- Kept in a personally-identifiable format only as long as needed for the purposes described below.

By providing my email address and enrolling in the Program, I consent to the transfer of my personal information via unsecured email between the Program, my Insurer and Healthcare Provider(s) for the purpose of determining my eligibility for the Program, conducting Program-related activities and the delivery of Program services.
I acknowledge that email is not a secure method of communication and that I can withdraw my consent at any time.
Your information may be transferred, stored, and/or processed outside of Canada, including the United States, where local laws will apply.

Drug Safety
Lilly has a legal obligation to report adverse drug events to Health Canada and to monitor product complaints. If you experience an adverse event or a product complaint, Lilly and our representatives will use and report your information for these purposes. Lilly may contact you or your physician for additional information to fulfill these obligations.

The Program
By enrolling in the Program, you authorize representatives of Lilly and their third-party patient support program providers to collect, use and disclose your personal information to provide the following services to:

PATIENT CONSENT AND PRIVACY, continued

- Provide product and disease state education
- Provide injection training and related services
- Provide new information regarding product and disease state
- Provide adherence and monitoring services
- Pursue funding to reimburse the cost of your Taltz therapy in part or in full, understanding that reimbursement is not guaranteed. Your physician may be contacted for additional information, if needed to complete your reimbursement request.
- Review your medical files for purposes of providing the Program services.
- Use your information on an anonymized basis to administer and monitor the Program, assess and demonstrate the effectiveness of the Program, carry out health economic and outcomes-based studies and analysis, and other commercial purposes.

Representatives of Lilly or their third-party patient support program providers may contact you for purposes including to:

- Provide Program services.
- Request feedback on your experience with the Program.
- Provide you with updated information on Taltz and the Program.

By enrolling in the Program and providing your email address, and/or a phone number for text messaging, you consent to being contacted by the Program via email and/or text message and to the transfer of your personal information via email and/or text message between the Program, your insurer, and your health care provider(s) for the purpose of determining your eligibility for the Program and the delivery of Program services. Email and/or text message may be used during the course of your participation in the Program to inform you about your status in the program and program services, and to provide notifications and reminders. You acknowledge that email and/or text message is not a secure method of communication. Information in emails has the potential to be accessed and read by a third party.

You do not have to participate in the Program in order to obtain Taltz. Eli Lilly Canada Inc. reserves the right to revise or discontinue this Program at any time and is under no obligation to provide you with any assistance at this time or in the future.

Withdrawing Consent
You can revoke this general authorization and withdraw from the Program by calling **1-877-219-8908**. If you do so, your withdrawal is not retroactive - any activities relating to your personal information prior to your withdrawal will not be affected. Your personal information will be deleted and/or maintained in accordance with applicable legislation, regulations, guidelines, and Lilly's Privacy Statement. You can also access or correct your personal information held by Lilly and its representatives. Any information retained by Lilly or their third-party patient support program providers will continue to be handled as described above and in accordance with Lilly's Privacy Statement.

PHYSICIAN CONSENT

I consent to be contacted by representatives of Eli Lilly and their third-party provider about the patient, Taltz, the Program. I consent to the use of my prescribing information for purposes of administering and monitoring the Program, to keep Eli Lilly representatives with whom I interact informed of my use of the Program (only on a patient de-identified basis) and to assess and demonstrate the effectiveness of the Program.

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