Please fax all pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Ebglyss™ (lebrikizumab-lbkz)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name ______ Last name ______ Middle initial ______

Preferred patient first name ______ Preferred patient last name ______

Sex at birth: ☐ Male ☐ Female Gender identity ______ Pronouns ______ Last 4 digits of SSN ______

Date of birth ______ Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ Email address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ Email address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ Email address ______

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Office/clinic/institution name ______

Prescriber info: Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______ Office contact email ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ Email ______

3 Clinical Information

Primary ICD-10 code (REQUIRED): ______

☐ NKDA ☐ Known drug allergies ______

Prior anaphylactic reaction: ☐ Yes (Reason/date ______) ☐ No

Concurrent meds ______

Patient wt ______kg Date wt obtained ______ Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued therapy

Patient's first name ______________________ Last name ______________________ Middle initial _____ Date of birth ___________

Prescriber's first name __________________________ Last name __________________________ Phone ______________________

4 Prescribing Information

Medication	Strength / Formulation and Directions	Quantity/Refills
☐ Ebglyss™ (lebrikizumab-lbkz) 250mg/2mL prefilled pen	**(For patients 12 years and older, must be ≥ 40kg)** ☐ **Starter Dose (no samples given):** Inject 500mg (2 pens) under the skin every 2 weeks on weeks 0 and 2, followed by 250mg (1 pen) every 2 weeks until week 16 or later ☐ **Starter Dose (first dose given as sample):** Inject 500mg (2 pens) under the skin on week 2, followed by 250mg (1 pen) every 2 weeks until week 16 or later	**Starter dose:** ☐ 4 prefilled pens (28-day supply) ☐ 2 prefilled pens (14-day supply)
	☐ **Induction Dose:** Inject 250mg (1 pen) under the skin every 2 weeks until week 16 or later, when adequate clinical response is achieved	**Induction dose:** ☐ 1-month supply ☐ 3-month supply Refills ____________
	☐ **Maintenance Dose:** Inject 250mg (1 pen) under the skin every 4 weeks	**Maintenance dose:** ☐ 1-month supply ☐ 3-month supply ☐ Other ____________ Refills ____________

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)**

SIGN HERE

_____________ **Date** ______________________ **Dispense as written** _____________ **Date** ______________________ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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