### 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 <u>MyAccredoPatients.com</u> to log in or get started.

## Prescription & Enrollment Form Ebglyss<sup>TM</sup> (lebrikizumab-lbkz)



### Four simple steps to submit your referral.

# **1** Patient Information

Plea and

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		Preferre	ed patient last nam	ne
Sex at birth: Male Female Gene	der 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 of	aregiver/contact			
Patient's primary language: English	Other If other, ple	ase specify		

## 2 Prescriber Information

Patient wt

All fields must be completed to expedite prescription fulfillment.

Date	1	Гіте		Date medication ne	eded	
Office/clinic/institu	tion name					
Prescriber info: Pre	escriber's first nam	1e		Las	t name	
Prescriber's title			If NP	or PA, under direc	tion of Dr	
Office phone		Fax		NPI #	Licens	se #
Office contact and	title			Office	e contact email	
Office street addres	SS					_ Suite #
City			State			Zip
Infusion location:	Patient's home	Prescriber's office	Infusion site	If infusion site, co	mplete information be	low dotted line:
Infusion info: Infus	ion site name			Clinic/hospital	affiliation	
Site street address						Suite #
City			State			Zip
Infusion site contact	t	Phon	e	Fax	Email	
3 Clinica	al Informat	ion				

#### 

\_\_\_\_kg Date wt obtained \_\_\_\_\_

1 of 2

#### Prescription & Enrollment Form: Ebglyss™ (lebrikizumab-lbkz)

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	<ul> <li>(For patients 12 years and older, must be ≥ 40kg)</li> <li>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</li> <li>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</li> </ul>	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

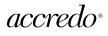
Date

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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