

Please fax all pages of completed form to your team at 866.531.1025.

To reach your team, call toll-free 866.839.2162.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](https://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

**Ebglyss™ (lebrikizumab-lbkz)**

*accredo®*

**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	<b>(For patients 12 years and older, must be ≥ 40kg)</b> <b>Starter Dose (no samples given):</b> 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 <b>Starter Dose (first dose given as sample):</b> Inject 500mg (2 pens) under the skin on week 2, followed by 250mg (1 pen) every 2 weeks until week 16 or later	<b>Starter dose:</b> 4 prefilled pens (28-day supply) 2 prefilled pens (14-day supply)
	<b>Induction Dose:</b> Inject 250mg (1 pen) under the skin every 2 weeks until week 16 or later, when adequate clinical response is achieved	<b>Induction dose:</b> 1-month supply 3-month supply Refills _____
	<b>Maintenance Dose:</b> Inject 250mg (1 pen) under the skin every 4 weeks	<b>Maintenance dose:</b> 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.