**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

# Elevidys (delandistrogene moxeparvovec-rokl)

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 _____

**Provider will read the following statement:** By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

## 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 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):** _____ Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: _____

Patient wt _____ Date wt obtained _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

AAVrh74 Antibody Test: ☐ Ordered ☐ Completed

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

Prescriber's first name _____ Last name _____ Phone _____

# 4 Prescribing Information

| Medication | Strength/Formulation | Directions | Quantity/Refills |
|---|---|---|---|
| Elevidys (delandistrogene moxeparvovec-rokl) | ELEVIDYS is provided in a customized kit containing ten to seventy 10mL single-dose vials, with each kit constituting a dosage unit based on the patient's body weight. All vials have a nominal concentration of $1.33 \times 10^{13}$ vg/mL | Administer as an intravenous infusion over 1-2 hours. Infuse at a rate of less than 10mL/kg/hour | 1 kit<br>No Refills |

| Weight (kg) | Patient Weight Range (kg) | Number of vials | Dose volume (mL) | Carton NDCs |
|---|---|---|---|---|
| ☐ 10 | 10.0 - 10.49 | 10 | 100 | 60923-0501-10 |
| ☐ 11 | 10.5 - 11.49 | 11 | 110 | 60923-0502-11 |
| ☐ 12 | 11.5 - 12.49 | 12 | 120 | 60923-0503-12 |
| ☐ 13 | 12.5 - 13.49 | 13 | 130 | 60923-0504-13 |
| ☐ 14 | 13.5 - 14.49 | 14 | 140 | 60923-0505-14 |
| ☐ 15 | 14.5 - 15.49 | 15 | 150 | 60923-0506-15 |
| ☐ 16 | 15.5 - 16.49 | 16 | 160 | 60923-0507-16 |
| ☐ 17 | 16.5 - 17.49 | 17 | 170 | 60923-0508-17 |
| ☐ 18 | 17.5 - 18.49 | 18 | 180 | 60923-0509-18 |
| ☐ 19 | 18.5 - 19.49 | 19 | 190 | 60923-0510-19 |
| ☐ 20 | 19.5 - 20.49 | 20 | 200 | 60923-0511-20 |
| ☐ 21 | 20.5 - 21.49 | 21 | 210 | 60923-0512-21 |
| ☐ 22 | 21.5 - 22.49 | 22 | 220 | 60923-0513-22 |
| ☐ 23 | 22.5 - 23.49 | 23 | 230 | 60923-0514-23 |
| ☐ 24 | 23.5 - 24.49 | 24 | 240 | 60923-0515-24 |
| ☐ 25 | 24.5 - 25.49 | 25 | 250 | 60923-0516-25 |
| ☐ 26 | 25.5 - 26.49 | 26 | 260 | 60923-0517-26 |
| ☐ 27 | 26.5 - 27.49 | 27 | 270 | 60923-0518-27 |
| ☐ 28 | 27.5 - 28.49 | 28 | 280 | 60923-0519-28 |
| ☐ 29 | 28.5 - 29.49 | 29 | 290 | 60923-0520-29 |
| ☐ 30 | 29.5 - 30.49 | 30 | 300 | 60923-0521-30 |
| ☐ 31 | 30.5 - 31.49 | 31 | 310 | 60923-0522-31 |
| ☐ 32 | 31.5 - 32.49 | 32 | 320 | 60923-0523-32 |
| ☐ 33 | 32.5 - 33.49 | 33 | 330 | 60923-0524-33 |
| ☐ 34 | 33.5 - 34.49 | 34 | 340 | 60923-0525-34 |
| ☐ 35 | 34.5 - 35.49 | 35 | 350 | 60923-0526-35 |
| ☐ 36 | 35.5 - 36.49 | 36 | 360 | 60923-0527-36 |
| ☐ 37 | 36.5 - 37.49 | 37 | 370 | 60923-0528-37 |
| ☐ 38 | 37.5 - 38.49 | 38 | 380 | 60923-0529-38 |
| ☐ 39 | 38.5 - 39.49 | 39 | 390 | 60923-0530-39 |

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
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.

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

Prescriber's first name _____ Last name _____ Phone _____

## 4 Prescribing Information

| Weight (kg) | Patient Weight Range (kg) | Number of vials | Dose volume (mL) | Carton NDCs |
|---|---|---|---|---|
| ☐ 40 | 39.5 - 40.49 | 40 | 400 | 60923-0531-40 |
| ☐ 41 | 40.5 - 41.49 | 41 | 410 | 60923-0532-41 |
| ☐ 42 | 41.5 - 42.49 | 42 | 420 | 60923-0533-42 |
| ☐ 43 | 42.5 - 43.49 | 43 | 430 | 60923-0534-43 |
| ☐ 44 | 43.5 - 44.49 | 44 | 440 | 60923-0535-44 |
| ☐ 45 | 44.5 - 45.49 | 45 | 450 | 60923-0536-45 |
| ☐ 46 | 45.5 - 46.49 | 46 | 460 | 60923-0537-46 |
| ☐ 47 | 46.5 - 47.49 | 47 | 470 | 60923-0538-47 |
| ☐ 48 | 47.5 - 48.49 | 48 | 480 | 60923-0539-48 |
| ☐ 49 | 48.5 - 49.49 | 49 | 490 | 60923-0540-49 |
| ☐ 50 | 49.5 - 50.49 | 50 | 500 | 60923-0541-50 |
| ☐ 51 | 50.5 - 51.49 | 51 | 510 | 60923-0542-51 |
| ☐ 52 | 51.5 - 52.49 | 52 | 520 | 60923-0543-52 |
| ☐ 53 | 52.5 - 53.49 | 53 | 530 | 60923-0544-53 |
| ☐ 54 | 53.5 - 54.49 | 54 | 540 | 60923-0545-54 |
| ☐ 55 | 54.5 - 55.49 | 55 | 550 | 60923-0546-55 |
| ☐ 56 | 55.5 - 56.49 | 56 | 560 | 60923-0547-56 |
| ☐ 57 | 56.5 - 57.49 | 57 | 570 | 60923-0548-57 |
| ☐ 58 | 57.5 - 58.49 | 58 | 580 | 60923-0549-58 |
| ☐ 59 | 58.5 - 59.49 | 59 | 590 | 60923-0550-59 |
| ☐ 60 | 59.5 - 60.49 | 60 | 600 | 60923-0551-60 |
| ☐ 61 | 60.5 - 61.49 | 61 | 610 | 60923-0552-61 |
| ☐ 62 | 61.5 - 62.49 | 62 | 620 | 60923-0553-62 |
| ☐ 63 | 62.5 - 63.49 | 63 | 630 | 60923-0554-63 |
| ☐ 64 | 63.5 - 64.49 | 64 | 640 | 60923-0555-64 |
| ☐ 65 | 64.5 - 65.49 | 65 | 650 | 60923-0556-65 |
| ☐ 66 | 65.5 - 66.49 | 66 | 660 | 60923-0557-66 |
| ☐ 67 | 66.5 - 67.49 | 67 | 670 | 60923-0558-67 |
| ☐ 68 | 67.5 - 68.49 | 68 | 680 | 60923-0559-68 |
| ☐ 69 | 68.5 - 69.49 | 69 | 690 | 60923-0560-69 |
| ☐ 70 | 69.5 and above | 70 | 700 | 60923-0561-70 |

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
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**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**

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