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

LENMELDY™ (atidarsagene autotemcel)

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.

Orchard COI ID ______________________

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

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 ______________________

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 __________ Estimated Apheresis Date ______________________

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 __________

QTC Info: QTC site name ______________________

Delivery address at the QTC for drug product ______________________ Suite # __________

City ______________________ State ______________________ Zip __________

QTC 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 ______________________

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
LENMELDY (atidarsagene autotemcel) suspension	**MLD Disease Subtype:** Pre-symptomatic late infantile Pre-symptomatic early juvenile Early symptomatic early juvenile Other: ____________ Dose may vary and is determined based on patient weight at time of infusion and cells produced during manufacturing process. See the Lot Information Sheet provided with the product shipment for additional information pertaining to dose.	Administer as a one time intravenous infusion. Each infusion bag contains approximately 10 to 20mL of LENMELDY and each bag must be infused within 2 hours after thawing. Administer each infusion bag of LENMELDY as an intravenous infusion within 30 minutes.	1 Dose supplied as 1 to 8 infusion bags. Complete number of bags supplied to be determined during the manufacturing process. No Refills

Recommended doses for MLD subtypes:

MLD Disease Subtype	Minimum Recommended Dose ($CD34^+$ cells/kg)	Maximum Recommended Dose ($CD34^+$ cells/kg)
Pre-symptomatic late infantile	4.2×10^6	30×10^6
Pre-symptomatic early juvenile	9×10^6	30×10^6
Early symptomatic early juvenile	6.6×10^6	30×10^6

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.

5 Patient Authorization

Authorization to Use/Disclose Health Information

I hereby authorize my/my child's treating physicians, health insurance plan(s), pharmacies, or other healthcare providers (collectively "Healthcare Providers") to use and disclose my/my child's protected health information related to my/my child's medical condition relevant to Orchard Therapeutics gene therapy to Orchard Therapeutics North America and its contractors and business partners. This authorization is made for the purpose of enrolling me/my child in Orchard Assist, providing me/my child with patient services, and administering the Orchard Assist Program. I understand that once my/my child's health information has been disclosed, federal privacy laws may no longer protect the information. However, Orchard Therapeutics agrees to protect my/my child's health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that I have the right to revoke this Authorization at any time by mailing a letter to Orchard Assist, 101 Seaport Boulevard, 7th Floor Boston, MA 02210 ATTN: Patient Advocacy or visiting **patient.advocacy@orchard-tx.com** I understand that if I revoke this Authorization, I/my child will no longer be able to receive Orchard Assist services.

This Authorization shall remain valid for ten (10) years from the date the Authorization is signed unless earlier revoked by my written request or in accordance with local laws. I understand that I have a right to receive a copy of this consent form. I understand that signing this consent form is voluntary and that my enrollment in any of the services and/or programs described above is entirely voluntary. I further understand that my/my child's treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my authorization of this disclosure, but if I do not sign this consent form, I/my child will not be able to receive Orchard Assist services.

I understand that certain parties, such as my/my child's pharmacy provider, may receive remuneration (payment) from Orchard Therapeutics North America in connection with the activities described in this consent form.

Please read the following statement and mark the box:

I hereby authorize the Orchard Assist Program to use my PHI to contact me by mail, email, text, phone, or any communication method I request for the purposes as described herein.

PATIENT AUTHORIZATION (to be completed by Patient or authorized representative)

By signing this form, I acknowledge that I understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my and/or my child's personal information, including sensitive personal information, pursuant to the Authorization to Use/Disclose Health Information and as otherwise stated on this form.

Patient Name (Printed) **Patient Signature**

Signature of Patient Representative*

***If signed by Patient Representative, please explain authority / relation to act on behalf of patient:**

Date (MM/DD/YYYY)

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Prior authorization checklist
LENMELDY™ (atidarsagene autotemcel)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with MLD. Coverage criteria may vary by payer.

	Referral form[1] (not required for electronic prescriptions)
	Completed LENMELDY referral form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits cards
	Clinical documents[2]
	Provide the following PA information to the form to prevent delay. This would include documenting or attesting to: • Arylsulfatase A (ARSA) activity below the normal range • Molecular genetic testing confirming presence of two disease-causing mutations in the ARSA gene • Elevated sulfatide levels in a 24-hour urine collection
	Attestation to: Patient has not previously received treatment with allogeneic hematopoietic stem cell transplantation (HSCT) or gene therapy for MLD or received allo-HSCT or GT previously or does not have evidence of residual cells of donor origin if the member has received a prior allo-HSCT. Please provide all necessary documentation.

Fax completed form to 800.330.0756.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.900.8397.

[1] For referral forms visit accredo.com.

[2] Ongoing management and documentation requirements:

- Initial improvement and continued need must be meticulously documented in progress notes
- All weaning must be attempted and documented as either amount or frequency
- Must be a stoppage in IVIG if sustained improvement is noted with weaning or no improvement has taken place at all

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IGL-00116-041625