Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Elevidys (delandistrogene moxeparvovec-rokl)

EVERNORTH HEALTH SERVICES

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 to patient: 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 Ambulation Status: ☐ Ambulatory ☐ Non-Ambulatory

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 1.33×10^{13} vg/mL	Administer as an intravenous infusion over 1-2 hours. Infuse at a rate of less than 10mL/kg/hour	1 kit 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
☐ 40	39.5 - 40.49	40	400	60923-0531-40
☐ 41	40.5 - 41.49	41	410	60923-0532-41

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

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 1.33×10^{13} vg/mL	Administer as an intravenous infusion over 1-2 hours. Infuse at a rate of less than 10mL/kg/hour	1 kit No Refills

Weight (kg)	Patient Weight Range (kg)	Number of vials	Dose volume (mL)	Carton NDCs
☐ 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.
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.

EVERNORTH HEALTH SERVICES

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