Please fax all pages of completed form to your team at 800.330.0756.
To reach your team, call toll-free 866.900.8397.
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

LENMELDY™ (atidarsagene autotemcel)

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.

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 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 _____ 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 _____

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

<table>
<tr><th>Medication</th><th>Strength/Formulation</th><th>Directions</th><th>Quantity/Refills</th></tr>
<tr>
<td>LENMELDY (atidarsagene autotemcel) suspension</td>
<td>
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.
<table>
<tr><th colspan="3">Recommended doses for MLD subtypes:</th></tr>
<tr><th>MLD Disease Subtype</th><th>Minimum Recommended Dose (CD34+ cells/kg)</th><th>Maximum Recommended Dose (CD34+ cells/kg)</th></tr>
<tr><td>Pre-symptomatic late infantile</td><td>4.2×10^6</td><td>30×10^6</td></tr>
<tr><td>Pre-symptomatic early juvenile</td><td>9×10^6</td><td>30×10^6</td></tr>
<tr><td>Early symptomatic early juvenile</td><td>6.6×10^6</td><td>30×10^6</td></tr>
</table>
</td>
<td>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.
Please see full Prescribing Information for LENMELDY</td>
<td>1 Dose supplied as 1 to 8 infusion bags. Complete number of bags supplied to be determined during the manufacturing process.
No Refills</td>
</tr>
<tr><td>☐ Other</td><td></td><td></td><td></td></tr>
</table>

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

EVERNORTH HEALTH SERVICES

Prior Authorization Checklist

LENMELDY™ (atidarsagene autotemcel)

Providing Evernorth 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. Orchard Therapeutics does not guarantee coverage or reimbursement for Orchard Therapeutics gene therapy.

Referral form[1]
(not required for electronic prescriptions)

- ☐ **Completed** LENMELDY referral form (available at accredo.com)
- ☐ **Copies of front and back** of all medical insurance and prescription benefit cards

Fax completed form to 800.330.0756.

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

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.

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[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.