Please fax both 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.

Prescription & Enrollment Form

Elevidys (delandistrogene moxeparvovec-rokl)

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 ______

Sex at birth: Male Female 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 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 1.33×10^{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	60923-501-10
11	10.5 - 11.49	11	110	60923-502-11
12	11.5 - 12.49	12	120	60923-503-12
13	12.5 - 13.49	13	130	60923-504-13
14	13.5 - 14.49	14	140	60923-505-14
15	14.5 - 15.49	15	150	60923-506-15
16	15.5 - 16.49	16	160	60923-507-16
17	16.5 - 17.49	17	170	60923-508-17
18	17.5 - 18.49	18	180	60923-509-18
19	18.5 - 19.49	19	190	60923-510-19
20	19.5 - 20.49	20	200	60923-511-20
21	20.5 - 21.49	21	210	60923-512-21
22	21.5 - 22.49	22	220	60923-513-22
23	22.5 - 23.49	23	230	60923-514-23
24	23.5 - 24.49	24	240	60923-515-24
25	24.5 - 25.49	25	250	60923-516-25
26	25.5 - 26.49	26	260	60923-517-26
27	26.5 - 27.49	27	270	60923-518-27
28	27.5 - 28.49	28	280	60923-519-28
29	28.5 - 29.49	29	290	60923-520-29
30	29.5 - 30.49	30	300	60923-521-30
31	30.5 - 31.49	31	310	60923-522-31
32	31.5 - 32.49	32	320	60923-523-32
33	32.5 - 33.49	33	330	60923-524-33
34	33.5 - 34.49	34	340	60923-525-34
35	34.5 - 35.49	35	350	60923-526-35
36	35.5 - 36.49	36	360	60923-527-36
37	36.5 - 37.49	37	370	60923-528-37
38	37.5 - 38.49	38	380	60923-529-38
39	38.5 - 39.49	39	390	60923-530-39
40	39.5 - 40.49	40	400	60923-531-40
41	40.5 - 41.49	41	410	60923-532-41

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
42	41.5 - 42.49	42	420	60923-533-42
43	42.5 - 43.49	43	430	60923-534-43
44	43.5 - 44.49	44	440	60923-535-44
45	44.5 - 45.49	45	450	60923-536-45
46	45.5 - 46.49	46	460	60923-537-46
47	46.5 - 47.49	47	470	60923-538-47
48	47.5 - 48.49	48	480	60923-539-48
49	48.5 - 49.49	49	490	60923-540-49
50	49.5 - 50.49	50	500	60923-541-50
51	50.5 - 51.49	51	510	60923-542-51
52	51.5 - 52.49	52	520	60923-543-52
53	52.5 - 53.49	53	530	60923-544-53
54	53.5 - 54.49	54	540	60923-545-54
55	54.5 - 55.49	55	550	60923-546-55
56	55.5 - 56.49	56	560	60923-547-56
57	56.5 - 57.49	57	570	60923-548-57
58	57.5 - 58.49	58	580	60923-549-58
59	58.5 - 59.49	59	590	60923-550-59
60	59.5 - 60.49	60	600	60923-551-60
61	60.5 - 61.49	61	610	60923-552-61
62	61.5 - 62.49	62	620	60923-553-62
63	62.5 - 63.49	63	630	60923-554-63
64	63.5 - 64.49	64	640	60923-555-64
65	64.5 - 65.49	65	650	60923-556-65
66	65.5 - 66.49	66	660	60923-557-66
67	66.5 - 67.49	67	670	60923-558-67
68	67.5 - 68.49	68	680	60923-559-68
69	68.5 - 69.49	69	690	60923-560-69
70	69.5 and above	70	700	60923-561-70

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.

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