

Duchenne Muscular Dystrophy

Enrollment Form



Fax Referral To: 1-844-802-1415

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-866-637-5394

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: Male Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

G71.01 Duchenne Muscular Dystrophy (DMD) Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____

Height: _____ in/cm:

Weight: _____ lb. or _____ kg

Date Weight Record: _____

5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|--|--|--|--|
| <input type="checkbox"/> Elevidys suspension | <input type="checkbox"/> 1.33 x 10 ¹³ vg/ml | Administer contents of kit as an intravenous infusion over 1-2 hours at a rate of less than 10ml/kg/hour as directed | Quantity: 1 Kit (kit determined by patient weight) |

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

| | |
|---|---|
| <p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p> | <p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p> |
| <p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p> | |

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Duchenne Muscular Dystrophy Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Prescriber Name: _____ Prescriber Phone: _____

Elevidys Multi-vial Kits

| Patient Weight (kg) | Total Vials per Kit | Total Dose Volume per Kit (ML) | NDC Number | Patient Weight (kg) | Total Vials per Kit | Total Dose Volume per Kit (ML) | NDC Number |
|--------------------------------------|---------------------|--------------------------------|--------------|---|---------------------|--------------------------------|--------------|
| <input type="checkbox"/> 10.0 – 10.4 | 10 | 100 | 60923-501-10 | <input type="checkbox"/> 40.5 – 41.4 | 41 | 410 | 60923-532-41 |
| <input type="checkbox"/> 10.5 – 11.4 | 11 | 110 | 60923-502-11 | <input type="checkbox"/> 41.5 – 42.4 | 42 | 420 | 60923-533-42 |
| <input type="checkbox"/> 11.5 – 12.4 | 12 | 120 | 60923-503-12 | <input type="checkbox"/> 42.5 – 43.4 | 43 | 430 | 60923-534-43 |
| <input type="checkbox"/> 12.5 – 13.4 | 13 | 130 | 60923-504-13 | <input type="checkbox"/> 43.5 – 44.4 | 44 | 440 | 60923-535-44 |
| <input type="checkbox"/> 13.4 – 14.4 | 14 | 140 | 60923-505-14 | <input type="checkbox"/> 44.5 – 45.4 | 45 | 450 | 60923-536-45 |
| <input type="checkbox"/> 14.5 – 15.4 | 15 | 150 | 60923-506-15 | <input type="checkbox"/> 45.5 – 46.4 | 46 | 460 | 60923-537-46 |
| <input type="checkbox"/> 15.5 – 16.4 | 16 | 160 | 60923-507-16 | <input type="checkbox"/> 46.5 – 47.4 | 47 | 470 | 60923-538-47 |
| <input type="checkbox"/> 16.5 – 17.4 | 17 | 170 | 60923-508-17 | <input type="checkbox"/> 47.5 – 48.4 | 48 | 480 | 60923-539-48 |
| <input type="checkbox"/> 17.4 – 18.4 | 18 | 180 | 60923-509-18 | <input type="checkbox"/> 48.5 – 49.4 | 49 | 490 | 60923-540-49 |
| <input type="checkbox"/> 18.5 – 19.4 | 19 | 190 | 60923-510-19 | <input type="checkbox"/> 49.5 – 50.4 | 50 | 500 | 60923-541-50 |
| <input type="checkbox"/> 19.5 – 20.4 | 20 | 200 | 60923-511-20 | <input type="checkbox"/> 50.5 – 51.4 | 51 | 510 | 60923-542-51 |
| <input type="checkbox"/> 20.5 – 21.4 | 21 | 210 | 60923-512-21 | <input type="checkbox"/> 51.5 – 52.4 | 52 | 520 | 60923-543-52 |
| <input type="checkbox"/> 21.5 – 22.4 | 22 | 220 | 60923-513-22 | <input type="checkbox"/> 52.5 – 53.4 | 53 | 530 | 60923-544-53 |
| <input type="checkbox"/> 22.5 – 23.4 | 23 | 230 | 60923-514-23 | <input type="checkbox"/> 53.5 – 54.4 | 54 | 540 | 60923-545-54 |
| <input type="checkbox"/> 23.5 – 24.4 | 24 | 240 | 60923-515-24 | <input type="checkbox"/> 54.5 – 55.4 | 55 | 550 | 60923-546-55 |
| <input type="checkbox"/> 24.5 – 25.4 | 25 | 250 | 60923-516-25 | <input type="checkbox"/> 55.5 – 56.4 | 56 | 560 | 60923-547-56 |
| <input type="checkbox"/> 25.5 – 26.4 | 26 | 260 | 60923-517-26 | <input type="checkbox"/> 56.5 – 57.4 | 57 | 570 | 60923-548-57 |
| <input type="checkbox"/> 26.5 – 27.4 | 27 | 270 | 60923-518-27 | <input type="checkbox"/> 57.5 – 58.4 | 58 | 580 | 60923-549-58 |
| <input type="checkbox"/> 27.5 – 28.4 | 28 | 280 | 60923-519-28 | <input type="checkbox"/> 58.5 – 59.4 | 59 | 590 | 60923-550-59 |
| <input type="checkbox"/> 28.5 – 29.4 | 29 | 290 | 60923-520-29 | <input type="checkbox"/> 59.5 – 60.4 | 60 | 600 | 60923-551-60 |
| <input type="checkbox"/> 20.5 – 30.4 | 30 | 300 | 60923-521-30 | <input type="checkbox"/> 60.5 – 61.4 | 61 | 610 | 60923-552-61 |
| <input type="checkbox"/> 30.5 – 31.4 | 31 | 310 | 60923-522-31 | <input type="checkbox"/> 61.5 – 62.4 | 62 | 620 | 60923-553-62 |
| <input type="checkbox"/> 31.5 – 32.4 | 32 | 320 | 60923-523-32 | <input type="checkbox"/> 62.5 – 63.4 | 63 | 630 | 60923-554-63 |
| <input type="checkbox"/> 32.5 – 33.4 | 33 | 330 | 60923-524-33 | <input type="checkbox"/> 63.5 – 64.4 | 64 | 640 | 60923-555-64 |
| <input type="checkbox"/> 33.5 – 34.4 | 34 | 340 | 60923-525-34 | <input type="checkbox"/> 64.5 – 65.4 | 65 | 650 | 60923-556-65 |
| <input type="checkbox"/> 34.5 – 35.4 | 35 | 350 | 60923-526-35 | <input type="checkbox"/> 65.5 – 66.4 | 66 | 660 | 60923-557-66 |
| <input type="checkbox"/> 35.5 – 36.4 | 36 | 360 | 60923-527-36 | <input type="checkbox"/> 66.5 – 67.4 | 67 | 670 | 60923-558-67 |
| <input type="checkbox"/> 36.5 – 37.4 | 37 | 370 | 60923-528-37 | <input type="checkbox"/> 67.5 – 68.4 | 68 | 680 | 60923-559-68 |
| <input type="checkbox"/> 37.5 – 38.4 | 38 | 380 | 60923-529-38 | <input type="checkbox"/> 68.5 – 69.4 | 69 | 690 | 60923-560-69 |
| <input type="checkbox"/> 38.5 – 39.4 | 39 | 390 | 60923-530-39 | <input type="checkbox"/> 69.5 and above | 70 | 700 | 60923-561-70 |
| <input type="checkbox"/> 39.5 – 40.4 | 40 | 400 | 60923-531-40 | | | | |

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

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| | |
|--|--|
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