Duchenne Muscular Dystrophy Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

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. 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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____**Relationship to minor**: _____

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
☐ Elevidys suspension	☐ 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)

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

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

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____	**Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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.