

# Duchenne Muscular Dystrophy Enrollment Form



Fax Referral To: 1-888-280-1191 OR 787-759-4161  
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Phone: 1-888-280-1190 OR 787-759-4162  
NCPDP: 4026325

## 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
<input type="checkbox"/> Elevidys suspension	<input type="checkbox"/> 1.33 x 10 <sup>13</sup> 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)

# Duchenne Muscular Dystrophy Enrollment Form

## 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
<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

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

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

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