FOR QUESTIONS PLEASE CALL: 800-511-5144
FAX COMPLETED FORM TO: 833-724-0006

NOTE: Hub enrollment with SareptAssist is mandatory for prescription processing.
VISIT: www.sarepta.com/sareptassist or call 1-888-SAREPTA to complete enrollment (if not already complete).

ELEVIDYS REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐M ☐F ☐Other:
SSN:	Phone:	Allergies:	
Address:	City:	State:	Zip:
Parent/Guardian:	Phone:	☐ **Please attach demographic information**	

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

SHIPPING INFORMATION

Site Name:	Infusion Date (if known):		
Delivery Address:	City:	State:	Zip:
Product Receipt Contact:	Phone:	Fax:	

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description): ☐ Duchenne Muscular Dystrophy (G71.01) ☐ Other: _____

Patient Weight: _____ ☐ lbs ☐ kg ***Date Weight Obtained:*** _____

Medical Records: Please attach a list of other medications patient is currently taking (with dosage and directions), a Genetic Test Report and AAVrh74 Antibody Test Results

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

PRESCRIPTION INFORMATION

Elevidys *(delandistrogene moxeparvovec-rokl)* **1.33 x 10^{13} vector genomes/mL**
Sig: Administer as an intravenous infusion over 1-2 hours. Infuse at a rate of less than 10 mL/kg/hr

Dispense: 1 KIT | Refills: 0

Check One Box to Select Kit

Patient Weight Range (kg)	Vials per Kit	Dose Volume (mL)
☐ 10.0 – 10.49	10	100
☐ 10.5 – 11.49	11	110
☐ 11.5 – 12.49	12	120
☐ 12.5 – 13.49	13	130
☐ 13.5 – 14.49	14	140
☐ 14.5 – 15.49	15	150
☐ 15.5 – 16.49	16	160
☐ 16.5 – 17.49	17	170
☐ 17.5 – 18.49	18	180
☐ 18.5 – 19.49	19	190
☐ 19.5 – 20.49	20	200
☐ 20.5 – 21.49	21	210
☐ 21.5 – 22.49	22	220
☐ 22.5 – 23.49	23	230
☐ 23.5 – 24.49	24	240
☐ 24.5 – 25.49	25	250
☐ 25.5 – 26.49	26	260
☐ 26.5 – 27.49	27	270
☐ 27.5 – 28.49	28	280
☐ 28.5 – 29.49	29	290

Patient Weight Range (kg)	Vials per Kit	Dose Volume (mL)
☐ 29.5 – 30.49	30	300
☐ 30.5 – 31.49	31	310
☐ 31.5 – 32.49	32	320
☐ 32.5 – 33.49	33	330
☐ 33.5 – 34.49	34	340
☐ 34.5 – 35.49	35	350
☐ 35.5 – 36.49	36	360
☐ 36.5 – 37.49	37	370
☐ 37.5 – 38.49	38	380
☐ 38.5 – 39.49	39	390
☐ 39.5 – 40.49	40	400
☐ 40.5 – 41.49	41	410
☐ 41.5 – 42.49	42	420
☐ 42.5 – 43.49	43	430
☐ 43.5 – 44.49	44	440
☐ 44.5 – 45.49	45	450
☐ 45.5 – 46.49	46	460
☐ 46.5 – 47.49	47	470
☐ 47.5 – 48.49	48	480
☐ 48.5 – 49.49	49	490

Patient Weight Range (kg)	Vials per Kit	Dose Volume (mL)
☐ 49.5 – 50.49	50	500
☐ 50.5 – 51.49	51	510
☐ 51.5 – 52.49	52	520
☐ 52.5 – 53.49	53	530
☐ 53.5 – 54.49	54	540
☐ 54.5 – 55.49	55	550
☐ 55.5 – 56.49	56	560
☐ 56.5 – 57.49	57	570
☐ 57.5 – 58.49	58	580
☐ 58.5 – 59.49	59	590
☐ 59.5 – 60.49	60	600
☐ 60.5 – 61.49	61	610
☐ 61.5 – 62.49	62	620
☐ 62.5 – 63.49	63	630
☐ 63.5 – 64.49	64	640
☐ 64.5 – 65.49	65	650
☐ 65.5 – 66.49	66	660
☐ 66.5 – 67.49	67	670
☐ 67.5 – 68.49	68	680
☐ 68.5 – 69.49	69	690
☐ 69.5 and above	70	700

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event AcariaHealth is unable to service due to payer restrictions, this prescription shall be forwarded to an in-network pharmacy.