

ELEVIDYS INFUSION ORDER

(delandistrogene moxeparovec-rokl)

1 PATIENT INFORMATION

Patient Name: _____
 Primary Phone: _____ DOB: _____
 Allergy: _____
 Gender: Male Female
 Diagnosis: *G71.01 Muscular Dystrophy* _____

2 PRESCRIBER INFORMATION

Prescribers Name: _____
 State License #: _____ NPI #: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

3 LAB RESULTS DOCUMENTATION

Please include DMD Genetic Test Results and AAVrh74 Antibody Test Results along with submission of this patient enrollment form as these test results may be required by the insurance provider.

4 ELEVIDYS PRESCRIPTION INFORMATION

ELEVIDYS is an adeno-associated virus vector-based gene therapy indicated for the treatment of ambulatory pediatric patients aged 4 through 5 years with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene. ELEVIDYS is supplied as a customized kit to meet dosing requirements for each patient. Each kit contains ten (10) to seventy (70) single dose vials of ELEVIDYS. All vials have a nominal concentration of 1.33×10^{13} vector genomes (vg)/mL. ELEVIDYS is for single-dose intravenous infusion only and is administered peripherally using a syringe pump with an in-line 0.2 micron filter over approximately 1 to 2 hours at a rate of less than 10mL/kg/hour.

Dose: ELEVIDYS 1.33×10^{14} vg/kg **Quantity:** 1 Kit **Refills:** No Refills **Patient Weight:** _____ Lbs _____ Kg **Date Weighed:** _____

Please check a box below to indicate patient dose. The intravenous dosage is determined by patient body weight:

Patient Weight Range (kg)	NDC Number	Patient Weight Range (kg)	NDC Number	Patient Weight Range (kg)	NDC Number	Patient Weight Range (kg)	NDC Number	Patient Weight Range (kg)	NDC Number
<input type="radio"/> 10.0 - 10.4	60923-501-10	<input type="radio"/> 14.5 - 15.4	60923-506-15	<input type="radio"/> 19.5 - 20.4	60923-511-20	<input type="radio"/> 24.5 - 25.4	60923-516-25	<input type="radio"/> 29.5 - 30.4	60923-521-30
<input type="radio"/> 10.5 - 11.4	60923-502-11	<input type="radio"/> 15.5 - 16.4	60923-507-16	<input type="radio"/> 20.5 - 21.4	60923-512-21	<input type="radio"/> 25.5 - 26.4	60923-517-26	<input type="radio"/> 30.5 - 31.4	60923-522-31
<input type="radio"/> 11.5 - 12.4	60923-503-12	<input type="radio"/> 16.5 - 17.4	60923-508-17	<input type="radio"/> 21.5 - 22.4	60923-513-22	<input type="radio"/> 26.5 - 27.4	60923-518-27	<input type="checkbox"/> Other, please specify (reference ELEVIDYS Prescribing Information for options)	
<input type="radio"/> 12.5 - 13.4	60923-504-13	<input type="radio"/> 17.5 - 18.4	60923-509-18	<input type="radio"/> 22.5 - 23.4	60923-514-23	<input type="radio"/> 27.5 - 28.4	60923-519-28		
<input type="radio"/> 13.5 - 14.4	60923-505-14	<input type="radio"/> 18.5 - 19.4	60923-510-19	<input type="radio"/> 23.5 - 24.4	60923-515-24	<input type="radio"/> 28.5 - 29.4	60923-520-29		
See ELEVIDYS Prescribing Information for a complete description of kit contents.									Weight Range (kg) NDC Number

5 PROVIDER SIGNATURE

Product Substitution Permitted Signature _____ Date of Signature _____ Dispense as Written Signature _____ Date of Signature _____

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