

BKEMV (eculizumab-aeeb) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐ NKDA Allergies:		Weight lbs/kg:	

PHYSICIAN INFORMATION

Physician Name:	Practice Name:		
Address:	Office Contact Name:	Office Contact #:	
Phone:	Fax:	Email (for updates):	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

MEDICATION ORDERS

☐ gMG who are anti-acetylcholine receptor (ArchR) antibody+

ICD 10: _____

gMG NEW START dosing (adult dosing)

- ☐ 900 mg weekly for the first 4 weeks, followed by
☐ 1,200 mg for the fifth dose 1 week later then
☐ 1,200 mg every 2 weeks x _____
 • Refills* ☐ None ☐ x6 months ☐ x1 year ☐ Other: _____
 *(if not indicated order will expire one year from date signed)

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)

ICD 10: _____

PNH BKEMV NEW START dosing (18 yo and older)

- ☐ 600 mg weekly for the first 4 weeks, followed by
☐ 900 mg for the fifth dose 1 week later then
☐ 900 mg every 2 weeks x _____
 • Refills* ☐ None ☐ x6 months ☐ x1 year ☐ Other: _____
 *(if not indicated order will expire one year from date signed)

☐ atypical Hemolytic Uremic Syndrome (aHUS)

ICD 10: _____

aHus NEW START dosing (18 yo and older)*

- ☐ 900 mg weekly for the first 4 weeks, followed by
☐ 1,200 mg for the fifth dose 1 week later then
☐ 1,200 mg every 2 weeks x _____
 • Refills* ☐ None ☐ x6 months ☐ x1 year ☐ Other: _____
 *(if not indicated order will expire one year from date signed)

PT wt and dosing	Body WT	Introduction	Maintenance
☐ WT _____	40kg and over	900mg weekly x 4 doses	1200mg at week 5 then 1200mg every 2 weeks
☐ WT _____	30kg to < 40kg	600mg weekly x 2 doses	900mg at week 3 then 900mg every 2 weeks
☐ WT _____	20kg to < 30kg	600mg weekly x 2 doses	600mg at week 3 then 600mg every 2 weeks
☐ WT _____	10kg to < 20kg	600mg weekly x 1 doses	300mg at week 2 then 300mg every 2 weeks
☐ WT _____	5kg to <10kg	300mg weekly x 1 doses	300mg at week 2 then 300mg every 3 weeks

***Complete or update vaccination from meningococcal bacteria (for serogroups A,C,W,Y, and B) at least 2 weeks prior to the first dose of BKEMV, unless the risks of delaying therapy with BKEMV outweigh the risk of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal bacteria in patients receiving a complement inhibitor. See Warning and Precautions (5.1) for additional guidance on the management of the risk of serious infections caused by meningococcal bacteria.

WARNINGS AND PRECAUTIONS

https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761333s001lbl.pdf

REQUIRED DOCUMENTATION CHECKLIST:

- ☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Clinical/ Progress notes supporting primary dx
☐ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)

Documentation of meningococcal vaccines

- ☐ WITH DATES OF ADMINISTRATION OF MEN B & MEN ACWY **OR**
☐ WITH DATES OF ADMINISTRATION OF MEN ABCWY **OR**
☐ IF NOT FULLY VACCINATED PROPHYLACTIC ANTIBX RM **MUST BE SENT**
☐ Is your patient enrolled in the BKEMV REMS program ☐ YES ☐ NO (If no, must be enrolled to start therapy)
☐ Is the ordering PROVIDER enrolled in the BKEMV REMS program ☐ YES ☐ NO (If no, must be enrolled to start therapy)

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Provider NPI _____