**Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

**Forest Hills**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

**NYC**
**E 56th & Park Midtown**
120 East 56 Street
Suite 300
New York, NY 10022

**E 70th St Upper East Side**
225 E 70th Street
Suite 1E
New York, NY 10021

**Sheepshead Bay**
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

**Long Island City**
36-36 33rd
Suite 311
Long Island City, NY 11106

**FIDI**
30 Broad Street
Suite 401
New York, NY 10004

**Central Park West**
115 Central Park West
Suite 15
New York, NY 10023

**Bronx**
226 West 238th Street
Bronx, NY 10463

**Massapequa**
97 Grand Avenue
Massapequa, NY 11758

**Gramercy**
7 Gramercy Park West
Lower Level
New York, NY, 10003

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Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

**Tarrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523

**Port Jefferson**
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

**Staten Island**
27 New Dorp Lane
Staten Island, NY 10306

**Southampton**
625 Hampton Road
Southampton, NY 11968

**Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

**Holbrook**
233 Union Avenue
Suite 207
Holbrook, NY 11741

**Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

**Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

**New Hyde Park**
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

**Woodbury**
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

# 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 ☐x1year ☐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 ☐x1year ☐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 ☐x1year ☐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.

### 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)

### WARNINGS AND PRECAUTIONS

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

**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 _____