Center City 1528 Walnut Street Suite 1205 Philadelphia, PA 19102





King Of Prussia 216 Mall Blvd Suite#1 King Of Prussia, PA, 19046

## **RKFMV**

BKEMV (eculizumab-a	Date:					
		PATIENT I		TION		
Name:		Phone:		DOB:	SEX:	M 🗆 F 🗆
□NKDA Allergies:				Weight lbs/kg:		
		PHYSICIAN	INFORM	ATION		
Physician Name:			Practice Name:			
Address:			Office Contact Name: Office Contact #:			
Phone: Fax:			Email (for updates):			
		REFERRA	L STATUS			
□New Referral □Referral Renewal	□Medi	cation/Order Cha	ange □Ben	efits Verificatio	n Only □Discon	tinuation 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			□ 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			
Refills* □None □x6 months □x1year □Other:     *(if not indicated order will expire one year from date signed     □ Paroxysmal Nocturnal Hemoglobinuria (PNH)		PT wt and dosing	<b>Body WT</b> 40kg and over	Introduction  900mg weekly x 4 doses	Maintenance 1200mg at week 5 then 1200mg every 2 weeks	
ICD 10:			□ wt	30kg to < 40kg	600mg weekly x 2 doses	900mg at week 3 then 900mg every 2 weeks
PNH BKEMV NEW START dosing (18 yo and older)			□ WT	20kg to < 30kg	600mg weekly x 2 doses	600mg at week 3 then 600mg every 2 weeks
□ 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			□ wr	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						
□ 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 vaccir	ies		J L			

- □ 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
- $\square$  Is your patient enrolled in the BKEMV REMS program  $\square$  YES  $\square$  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

ONDERINGTROVIDER						
Signature <b>X</b>		Date				
Provider	Phone	Provider NPI				