Vermont
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ThrIVewell™ INFUSION
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Mission Medical

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 _____