Eculizumab (BKEMV)

Provider Order Form rev. 07/28/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Generalized myasthenia gravis:

Other: Description:

REQUIRED INFORMATION

MenACWY: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
Meb B: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
(Trumenba only) Date of 3rd dose: _____
Prophylactic antibiotics prescribed: ☐ Yes / ☐ No
Date patient started prophylactic antibiotics *(if applicable)*: _____
Provider REMS ID: _____

☐ **For gMG diagnosis**: Patient is anti-acetylcholine receptor antibody positive (provide documentation)

☐ **For gMG diagnosis:** Meningococcal vaccine(s) given on _____date. First BKEMV dose may be given at least 2 weeks later unless otherwise specified.

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Administer eculizumab (BKEMV) 900mg weekly[1] x4 doses. Dilute with 90 ml 0.9% sodium chloride *(final volume 180 ml)* and infuse over 35 minutes.

☐ Administer eculizumab (BKEMV) 1200mg for the fifth dose one week after the fourth dose (week 5), then every 2 weeks[1] thereafter. Dilute with 120 ml 0.9% sodium chloride *(final volume 240 ml)* and infuse over 35 minutes.

☐ Other: Administer eculizumab (BKEMV)_____
_____

☑ If infusion is stopped for any reason, total infusion time should not exceed 2 hours

☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion

[1]Recommended dosage time intervals; may adjust +/- 2 days if needed

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection or meningococcal infection such as:
  - Headache with (1) fever, (2) nausea/vomiting, (3) stiff neck/back
  - Muscle aches with flu-like symptoms, fever with or without rash, confusion or photophobia

☑ Ensure patient carries and understands Patient Safety Information Card.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Disease status, MRI, Flow Cytometry, MG classification, MG-ADL score, EMG results
Required Labs: Anti-Ach receptor, Anti-AQP4,

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.