BKEMV™ (eculizumab-aeeb) Referral Form

Preferred Clinic (select one): _____

PATIENT INFORMATION

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Infusion Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC w/ diff every _____

☐ CMP every _____

☐ OTHER _____

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

REQUIRED DOCUMENTATION

- ☐ **Patient Demographics**
- ☐ **Insurance Card/Information**
- ☐ **Progress Notes Supporting DX**
- ☐ **Current Medication List and H&P**
- ☐ **MG-ADL Score _____**
- ☐ **Positive AQP4**
- ☐ **Patient has had the meningococcal vaccines (both MenACWY and MenB)**
- ☐ **MGFA Classification _____**
- ☐ **Complete Metabolic Panel**
- ☐ **Positive AchR (gMG)**
- ☐ **Patient is registered in the BKEMV REMS program**

BKEMV ADMINISTRATION

PNH DIAGNOSIS

☐ Initial Dosing: 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter

☐ Maintenance Dose: 900mg IV every 2 weeks x 1 year

aHUS and gMG DIAGNOSIS

☐ Initial Dosing: 900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

☐ Maintenance Dose: 1200mg IV every 2 weeks

☐ aHUS only - weight based dosing for patients less than 18 years old

Provider Name (Print) **Provider Signature** **Date**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below **Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

Referral is valid for one year unless otherwise noted.

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