Nipocalimab-aahu (Imaavy)

Provider Order Form rev. 07/30/2025

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)***

Myasthenia Gravis (with positive anti-acetylcholine receptor antibodies):

Other: Description:

REQUIRED INFORMATION

Date of last dose (if applicable) _____

Lab results showing positive AChR or MuSK antibody.

THERAPY ADMINISTRATION & DOSING

☐ Administer initial dose of 30 mg/kg _____mg intravenously over at least 30 mins. Followed by administering 15 mg/kg _____mg intravenously over at least 15 mins every 2 weeks beginning 2 weeks after the initial dose. Flush IV line with NS after each infusion.

☐ Administer 15 mg/kg _____mg intravenously over at least 15 mins every 2 weeks. Flush line with NS after each infusion.

☑ Monitor patient for 30 mins after each infusion.

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 abnormal vital signs or signs/symptoms of active infection or recent live vaccine.

☑ Monitor vital signs before, with each rate change and after infusion observation period.

☑ 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.

Required Labs: AChR antibody, MuSK antibodies, MG classification, MgADL score, 2 OVN with treatment.

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.