



Imaavy (nipocalimab-aahu) I Order Form

Patient Name:		1	DOB:	Phone:		
Address:		City:		State:	Zip:	
	please submit with form:					
• Copy of	f insurance card • Demogr	aphics • Progress n	otes, including: H&P, diagn	osis documentation, tre	eatment history	
• Labs, in	cluding positive antibody test	results • Severity of	f symptoms, such as MG-AI	OL and MGFA, if availab	e	
2. Patient Information	on					
Male Female	Height: in	cm Weight:	lbs kg Allergies:			
	e? Yes No, date of last inf					
3. Primary Diagnosis						
	vis with (acute) exacerbation (G70.01) Myastheni	a Gravis without (acute) ex	acerbation (G70.00)	Other ICD-10:	
4. Prescription Infor	nation					
Imaavy (nipocalin	nab-aahu): 1200 mg/6.5 mL ar	nd/or 300 mg/1.62 mL	single dose vial(s)			
Dosing / Frequency		t 15 minutes once ever		wo weeks after the initi	al infusion, infuse	
• Prepare infusion per manufacturer guidelines. Withdraw calculated dose from vials and discard any unused vial con Dilute required volume of Imaavy by adding to an infusion container containing 0.9% sodium chloride injection to volume of 250 mL for patients who weigh 40 kg or more, or 100 mL for patients who weigh less than 40 kg • Administer diluted solution via IV infusion using ≤ 0.2 micron filter over at least 30 minutes for the initial infusion ar						
	 Administer diluted soluti least 15 minutes for sub 			least 30 minutes for the	e initial infusion and at	
Quantity / Refills		Dispense quantity sufficient for one month supply				
	• Refill x 12 months Oth	Refill x 12 months				
5. Additional Orders						
	heral IV or use existing CVC. RI	N to administer catheti	er flushing ner Policy and Pu	rocedure		
• •	tional): Give 30 min prior to inf		0. ,			
• •	nts weighing >40kg):	, ,	Weighing <40 kg: (may adjust with weight changes)			
Diphenhydramine 25-50mg PO. Patient ma		y decline.	Diphenhydramine 1mg/kg PO			
Acetaminophen 325-650mg PO. Patient ma			Acetaminophen 15m			
Methylprednisolone 40mg (ORm equivalent corticosteroid, substitution if neede			Methylprednisolone 1 mg/kg (ORmg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)			
	bosteroid, substitution in freedo	sa sy pharmacy,	equivalent conticosteron	a, substitution in necuci	a by pharmacy,	
Other: RN to monitor pa	atient for at least 30 min post i	nfusion and educate o	n possible side effects, aller	rgic reactions, and wher	n to contact physician	
·	·		,	,	. ,	
6. Adverse Reaction C	Orders					
 Standard anaph and NS IV. Addit 	ylaxis kit to be dispensed and ditional orders:	dosed per protocol: Ep	inephrine IM/SQ (1 mg/mL	vial), diphenhydramine	IV/IM (50 mg/mL vial),	
7. Prescriber Informa						
					p:	
Phone:		_ Fax:				
License No.:		DEA No.:		NPI:		
Physician Signature (Substitution Permitted)		 Date	Physician Signature (Dispense as Written)	 Date	
,	. ,		, 5.5.5 5.8 (

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