promptcare

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Imaavy (nipocalimab-aahu) I Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City:_____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card
- Demographics
- Progress notes, including: H&P, diagnosis documentation, treatment history
- Labs, including positive antibody test results
- Severity of symptoms, such as MG-ADL and MGFA, if available

2. Patient Information

☐Male ☐Female Height: _____ ☐in ☐cm Weight: _____ ☐lbs ☐kg Allergies: _____
Is this the first dose? ☐Yes ☐No, date of last infusion: _____ Next dose due: _____ Line type: ☐PIV ☐PICC ☐Port ☐Other

3. Primary Diagnosis

☐ Myasthenia Gravis with (acute) exacerbation (G70.01) ☐ Myasthenia Gravis without (acute) exacerbation (G70.00) ☐ **Other** ICD-10: _____

4. Prescription Information

☒ **Imaavy (nipocalimab-aahu):** 1200 mg/6.5 mL and/or 300 mg/1.62 mL single dose vial(s)	
Dosing / Frequency	☒ Infuse 30 mg/kg IV over at least 30 minutes one time for initial infusion. Two weeks after the initial infusion, infuse 15 mg/kg IV over at least 15 minutes once every 2 weeks ongoing. ☐ **Other:** _____
Administration	• Prepare infusion per manufacturer guidelines. Withdraw calculated dose from vials and discard any unused vial contents. Dilute required volume of Imaavy by adding to an infusion container containing 0.9% sodium chloride injection to a final 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 and at least 15 minutes for subsequent doses, as tolerated and per protocol
Quantity / Refills	• Dispense quantity sufficient for one month supply • Refill x 12 months ☐ Other: _____ • Dispense all medical supplies necessary for infusion

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Policy and Procedure

Premedication (optional): Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

Adults (or patients weighing >40kg):

- ☐ Diphenhydramine 25-50mg PO. Patient may decline.
- ☐ Acetaminophen 325-650mg PO. Patient may decline.
- ☐ Methylprednisolone 40mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

Weighing <40 kg: *(may adjust with weight changes)*

- ☐ Diphenhydramine 1mg/kg PO
- ☐ Acetaminophen 15mg/kg PO
- ☐ Methylprednisolone 1 mg/kg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

☐ Other: _____

☒ RN to monitor patient for at least 30 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders

- Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License No.: _____ DEA No.: _____ NPI: _____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date