Local Infusion

MYLOCALINFUSION.COM

IMAAVY (NIPOCALIMAB-AAHU) INJECTION ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Myasthenia gravis without (acute) exacerbation, ICD 10: G70.00
❑ Myasthenia gravis with (acute) exacerbation, ICD 10: G70.01
❑ Warm autoimmune hemolytic anemia (wAIHA) in adult and pediatric patients 12 years of age and older currently or previously treated with corticosteroids, ICD 10: D59.11
❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Imaavy	❑ Initial Dose: 30mg/kg, then 2 weeks later 15mg/kg and continue every 2 weeks ❑ 30mg/kg every 4 weeks	IV

LABS / SPECIAL INSTRUCTIONS