Imaavy® Order Form
(nipocalimab-aahu)

medix infusion

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

ICD 10 Code Required

☐ G70.00 Myasthenia Gravis without (acute) exacerbation

☐ G70.01 Myasthenia Gravis with (acute) exacerbation

☐ Other ICD 10 Code: _____

Description _____

Medication Order

Initial Dose

☐ ≥ 40kg: total infusion volume is 250mL - 30mg/kg IV once at week 0

☐ < 40kg: total infusion volume is 100mL - 30mg/kg IV once at week 0

Maintenance dosing (adult)

☐ ≥ 40kg: total infusion volume is 250mL - 15mg/kg IV every 2 weeks beginning at week 2

☐ < 40kg: total infusion volume is 100mL - 15mg/kg IV every 2 weeks beginning at week 2

Pre-Medication Orders

☐ Acetaminophen 650mg PO

☐ Cetirizine 10mg PO

☐ Loratadine10mg PO

☐ Diphenhydramine 25mg PO

☐ Diphenhydramine 25mg IV

☐ Methylprednisolone _____ mg SIVP

☐ Hydrocortisone (Solu-Cortef) _____mg IV

☐ Other: _____

Lab Orders

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

Required Clinical Documentation

☐ Clinical/Progress notes with supporting diagnosis

☐ H & P _____

☐ Positive serologic test for anti-AChR antibody for gMG

☐ Positive serologic test for anti-MuSK antibody for gMG

☐ MG-ADL Score: _____

☐ MGFA classification:_____

☐ Patient's demographics, including insurance information

☐ Please attach original prescription orders

☐ Current Medications: _____

☐ Previous Therapies

☐ Eculizumab ☐ Oral Corticosteroids

☐ Rituximab ☐ Non-Steroidal ISTs

☐ IVIG ☐ Previous Live Vaccine: _____ Date: _____

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

If yes, please note therapy and last dose:

_____

Medix Infusion will collect all necessary labs if not included in referral document

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____