

Nipocalimab-aahu (Imaavy)

Provider Order Form rev. 07/30/2025



PATIENT INFORMATION

Patient Name:	DOB:	Patient Phone:	
Patient Address:	Patient Email:		
Allergies:	<input type="checkbox"/> NKDA	Weight (lbs/kg):	Height (in/cm):
Sex: <input type="checkbox"/> M / <input type="checkbox"/> 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: _____

LABORATORY ORDERS

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.