

Nipocalimab-aahu (Imaavy)

Provider Order Form rev. 07/30/2025



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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.

ADDITIONAL ORDERS

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

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.