FAX: 725.228.5220 eMediate INFUSION

IMAAVY

☐ New Prescription/Referral
☐ Prescription Refill

Of Refills:

PATIENT INFORMATION

*Patient Insurance & ID (front and back) are needed

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Imaavy:
(Nipocalimab-Aahu)

☐ Initial:
30 mg/kg IV x 1 dose over at least 30 mins one time , followed by 15 mg/kg every 2 weeks beginning 2 weeks after first dose

☐ Maintenance:
15 mg/kg IV every 2 weeks

☐ Others: _____

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg ☐ 1000mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis: ☐ Myasthenia Gravis w/out acute exacerbation (ICD-10 Code: G70.00)
☐ Myasthenia Gravis w/ acute exacerbation (ICD-10 Code: G70.01)
☐ Other: _____
☐ ICD-10: _____

gMG Classification: ☐ II ☐ III ☐ IV

PRESCRIBER SIGNATURE: x

Date (Valid for 1 year):

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
☐ Lab results showing positive AChR or MuSK antibody

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot