

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- G70.00 Myasthenia gravis w/o acute exacerbation (gMG)
- G70.01 Myasthenia gravis with acute exacerbation (gMG)
- ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information
- List of Medications
- Tried & Failed Therapies
- Most Recent History & Physical
- MG-ADL Score / MGFA Classification
- Positive AChR Antibody (gMG)

MEDICATION ORDER

- INDUCTION:** IMAAVY® (nipocalimab-aahu) 30 mg/kg IV in 100 ml – 250 ml NS over 30 minutes
- MAINTENANCE:** IMAAVY® (nipocalimab-aahu) 15 mg/kg in 100 ml – 250 ml NS filter over 20 minutes every 2 weeks
(250 ml NS for patients weighing ≥ 40 kg, 100 ml NS for patients weighing < 40 kg)

PRE-MEDICATIONS

- PO**
 - Acetaminophen: 650 mg
 - Cetirizine: 10 mg
 - Diphenhydramine: 25 mg
- IV**
 - Methylprednisolone: 125 mg
 - Diphenhydramine: 25 mg
- OTHER:** _____ PO IV

Patient to be observed for 30 minutes following each infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN