NIPOCALIMAB-AAHU ORDERS (Imaavy)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Immunization status
☐ Completed and Signed Referral
☐ CBCwdiff/CMP/IgG lab results
☐ EMG Results
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

NIPOCALIMAB-AAHU ORDERS (Imaavy)

CENTERS AT SIC
An Access Infusion Care Managed Company

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐PIV ☐PICC ☐Port ☐Other:

DIAGNOSIS
☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance ☐ H&P, labs, tests, progress notes supporting Dx	
Prior Therapies:	
☐Positive AChR antibody/MuSK antibody screening (attach results)	☐MG-ADL Score:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐CMP ☐CBCwdiff ☐Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐650mgPO ☐1000mgPO	Methylprednisolone: ☐100mgIV ☐125mgIV ☐ mgIV
Diphenhydramine: ☐25mgPO ☐50mgPO ☐25mgIV ☐50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒**Nipocalimab (Imaavy)**	185mg/mL	☐**Induction: 30mg/kg** Infuse in 250ml(>40kg)/100ml(<40kg) 0.9%NS IV over 30 minutes x 1 dose	☐# sufficient for weight-based dose Refills: None
		☐**Maintenance: 15mg/kg** (Begins 2 weeks after induction dose) Infuse in 250ml(>/=40kg)or 100ml(<40kg)0.9%NS IV over at least 15 minutes every 2 weeks	☐# sufficient for weight-based dose Refills:

Use current documented weight; round calculated dose to nearest vial size +/- 10% of dose.
If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 30 minutes after the infusion.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

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