RED RIVER HEALTH
Ambulatory Infusion Clinic

Jonesboro, AR: AICJonesboro@RedRiverRX.com **Fax:** 1-870-558-4101
Texarkana, TX: AICTexarkana@RedRiverRX.com **Fax:** 1-844-547-1957

IMAAVY (nipocalimab-aahu) Order

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ __G70.00___ Myasthenia gravis w/o exacerbation ☐ __G70.01___ Myasthenia gravis w/ exacerbation

Pre-Medication:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☑ Anti-AChR antibody results & date
☑ MG-ADL score, documented tried & failed therapies

IMAAVY IV Infusion:

Pt. weight: _____
(ensure unit of measure is noted)

☑ Dilute dose in 0.9% sodium chloride; patients weighing greater than 40kg total volume of 250mL, less than 40kg total volume 100mL - administer IV with 0.2 filter.

☐ **Initial Dose:** 30mg/kg over 30 minutes

☐ **Maintenance Dosing:** 15mg/kg over 15 minutes

Maintenance frequency: Every 2 weeks

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: