Imaavy (nipocalimab-aahu)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE
☐ Myasthenia gravis without (acute) exacerbation ICD 10 Code: G70.00 ☐ Myasthenia gravis with (acute) exacerbation ICD 10 Code: G70.01 ☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐
List Tried & Failed Therapies 1)	2)

PREMEDICATION ORDERS
☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg ☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered) ☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐100mg ☐ 125mg ☐ _____ mg ☐ Other:

MEDICATION ORDERS	
Initial	☐ Imaavy 30 mg/kg IV once then 15 mg/kg IV every 2 weeks thereafter
Maintenance	☐ Imaavy 15 mg/kg IV every 2 weeks
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated order will expire one year from date signed)*	

SPECIAL INSTRUCTIONS

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Created 1/30/26