

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

- | | |
|---|---|
| <input type="checkbox"/> Allenmore Infusion Center | <input type="checkbox"/> DHEC Infusion Center |
| <input type="checkbox"/> Auburn Infusion Center | <input type="checkbox"/> North Spokane Infusion Center |
| <input type="checkbox"/> Gig Harbor Infusion Services | <input type="checkbox"/> North Star Lodge Infusion Center |
| <input type="checkbox"/> Puyallup Infusion Center | |

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Nipocalimab-aahu (Imaavy®)

Patient Name: _____ Requested Date of Service: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Patient Phone Number: (____) ____ - ____ May leave message

Diagnosis: Myasthenia Gravis **ICD -10 Code:** _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

*Vaccination with live vaccines is not recommended

Baseline Labs Required:

- Pregnancy
- CBC
- Cholesterol

Maintenance Labs:

- CBC monthly
- Cholesterol every 3 months

Treatment Regimen:

- Nipocalimab-aahu (Imaavy®) 30 mg/kg IV initially followed by 15 mg/kg IV every 2 weeks
Administer the first dose over at least 30 minutes, subsequent doses over at least 15 minutes. Monitor patients closely during all infusions for at least 30 minutes.

*100 ml NS for pts <40 kg; NS 250 ml for pts 40 kg and greater

- Vital signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature _____ Print Name _____ Date _____ Time _____

Another brand of drug, identical in form and content, may be dispensed unless checked **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:
MRN #:
CSN #:
Age / Sex and Gender:

Pre-printed Order

MYASTHENIA GRAVIS

MultiCare 



60-0371-4 (10/25)