REVITALIZE
INFUSION CENTER

Imaavy™

Infusion Order Form

Patient Information:

_____	_____	_____
Patient Name	**DOB**	**Phone Number**

Medical Information:

Primary Diagnosis:

☐ Myasthenia gravis without (acute) exacerbation ICD-10 Code: G70.00

☐ Myasthenia gravis with (acute) exacerbation ICD-10 Code: G70.01

☐ Other_____ ICD-11 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Relevant labs and tests including:
  - Anti-AChR+ Serology and/or MuSK+ serology
- Medication List
  - Documentation of previously trialed and failed therapies including most recent administration date, documentation of intolerance, contraindication or rationale for discontinuation
- Vaccination Records

Height: _____

Weight: _____

Imaavy (nipocalimab-aahu) Orders:

☐ Initial Dose: Administer 30 mg/kg (_____ mg) intravenously over 30 minutes for one dose

☐ Maintenance Dosing: Administer 15 mg/kg (_____ mg) intravenously over 15 minutes two weeks after the prior dose and every two weeks thereafter to provide infusions for one year (26 doses authorized)

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____	_____
Prescriber's Signature	**Date**
_____	_____
Prescriber's Printed Name	**Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize | Revitalize Locations | InfusionPlus