Fax: 832-895-4040
Phone: 832-895-5000
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adaptIV infusion

Imaavy (Nipocalimab-aahu)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ____________________ DOB: __________

NKDA ☐ Allergies: ____________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): __________ ICD-10 description: ____________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: ____________________
Dose: __________ Route: __________
Frequency: ____________________

THERAPY ADMINISTRATION

☐ **Imaavy (Nipocalimab-aahu)** in 0.9% Sodium Chloride, IV infusion
Patients ≥ 40kg: total infusion volume is 250mL
Patients <40kg: total infusion volume is 100mL

Please indicate if both induction and maintenance doses are needed:

☐ Induction:
- Dose: 30mg/kg
- Frequency: once at week 0
- Route: intravenous
- Infuse over 30 minutes with a 0.2-micron filter.
  (maintenance doses will be given every 2 weeks thereafter)

☐ Maintenance:
- Dose: 15mg/kg
- Frequency: every 2 weeks beginning at week 2
- Route: intravenous
- Infuse over 15 minutes with a 0.2-micron filter.

☐ Flush with 0.9% sodium chloride at infusion completion
☐ Patient is required to stay for 30-minute observation post infusion
☐ Refills: ☐ Zero ☐ for 12 months ☐ __________
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: __________ Referral Coordinator Email: __________
Ordering Provider: __________ Provider NPI: __________
Referring Practice Name: __________ Phone: __________ Fax: __________
Practice Address: __________ City: __________ State: ______ Zip Code: ______

Provider Name (Print) ____________________ *Provider Signature* ____________________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK