IMAAVY™ (NIPOCALIMAB-AAHU) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Prescription

☐ **IMAAVY™ (NIPOCALIMAB-AAHU)**

- Infuse 30 mg/kg IV over at least 30 minutes one time.
- Two weeks after the initial infusion, and every two weeks ongoing, infuse 15mg/kg IV over at least 15 minutes. Refill x 1 year.
- Infuse using 0.2 micron filter.
- Dispense quantity sufficient of 300mg and/or 1200mg single dose vials for each dose. Round dose to nearest measurable volume (0.1mL)
- Withdraw calculated dose from vial(s) and discard any unused vial contents.

☐ Additional orders: _____

Ancillary Orders

Anaphylaxis Kit

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Other Orders:

☐ _____

IV Flush Orders:

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. If peripheral IV, RN to insert. If port, RN to access. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary and that I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

