

IMAAVY™ (NIPOCALIMAB-AAHU) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:		Gender:	
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Prescription				
<p><input type="checkbox"/> IMAAVY™ (NIPOCALIMAB-AAHU)</p> <ul style="list-style-type: none"> • 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. <p><input type="checkbox"/> Additional orders: _____</p>				
Ancillary Orders				
<p>Anaphylaxis Kit</p> <ul style="list-style-type: none"> • 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 (\leq 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 (\leq 30 kg) IV at KVO rate PRN anaphylaxis. 				
<p>Other Orders:</p> <p><input type="checkbox"/> _____</p>				
<p>IV Flush Orders:</p> <p><input type="checkbox"/> <u>Peripheral</u>: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.</p> <p><input type="checkbox"/> <u>Implanted Port</u>: 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.</p>				
<p>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.</p> <p>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.</p>				
<p><i>I certify that the use of the indicated treatment is medically necessary and that I will be supervising the patient's treatment.</i></p>				
Prescriber Signature: _____			Date: _____	
Prescriber Information				
Prescriber Name:		Phone:	Fax:	
Address:		NPI:		
City, State:		Zip:	Office Contact:	
<p>Fax completed form, insurance information, and clinical documentation to: 713-983-4647</p> <p>CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</p>				