Imaavy™
Provider Order Form Rev. 5/2025
Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Myasthenia Gravis without (acute) exacerbation, G70.00
☐ Myasthenia Gravis with (acute) exacerbation, G70.01
☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Imaavy™ (nipocalimab)	☐ Initial: _____ mg (30 mg/kg) ☐ Maintenance: _____ mg (15 mg/kg)	☐ Initial: Infuse IV over 30 minutes x 1 dose ☐ Maintenance (starts 2 weeks after initial dose): Infuse IV over 15 minutes once every 2 weeks x 1 year *Observe patient for 30 minutes after completion of each infusion.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____
☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient is positive for anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibodies.
Please specify:
- ☐ Anti-acetylcholine receptor (AChR) antibody
- ☐ Anti-muscle-specific tyrosine kinase (MuSK) antibody

☐ The patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease.
- Clinical Classification: _____

☐ The patient has a baseline MG-Activities of Daily Living (MG-ADL) score of ≥ 5.
- MG-ADL score: _____

LAB AND TEST RESULTS (required)

☐ Anti-acetylcholine Receptor (AChR) Antibodies
☐ Anti-muscle-specific tyrosine kinase (MuSK) Antibodies
☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation Form
☐ Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____