

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____
 Date of Birth: _____ Address: _____
 Allergies See List NKDA City, State, Zip: _____
 Weight: _____ kg lbs Height: _____ in cm Email: _____

PRIMARY DIAGNOSIS

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

PRESCRIPTION

Imaavy single-dose vial: 1200mg/6.5mL

Initial dose: 30mg/kg IV at week 0

Check one: Up to 40kg: 1 vial 41kg-80kg: 2 vials 81kg-120kg: 3 vials 121kg-160kg: 4 vials 161kg-200kg: 5 vials

Maintenance Dose: 15mg/kg IV every 2 weeks x 1 year

Check one: Up to 80kg: 1 vial 81kg-160kg: 2 vials 160kg-200kg: 3 vials

Other: _____

Has patient received any doses of this medication in the past? Yes No

Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most recent labs
- H&P
- Medication List
- Tried and Failed therapies (including duration)

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. (See aiscargroup.com for detailed policy)

Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No pre-meds recommended for Imaavy.

Provider Prescribed: _____

LINE CARE ORDERS

Start PIV/Access CVC Flush device per Advanced Infusion Care Centers' protocol (See aiscargroup.com for detailed policy)

Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

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