Atrium Health

**Atrium Health Infusion Center**

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|---|---|
| Referral Status: | ☐ New Start ☐ Order Change ☐ Renewal |
| Preferred Location: | ☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401<br>☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401<br>☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401<br>☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401<br>☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390<br>☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390<br>☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390 |

**Imaavy™ (nipocalimab-aahu) Infusion Order** (Revised 2/11/2026)

All orders with a √ will be placed.

| **Patient Demographics:** | | |
|---|---|---|
| Patient Name: | | Date of Birth: |
| Address: | | |
| City: | State: | Zip Code: |
| Allergies: (please list all allergies or attach list) | | |
| ☐ NKDA | | |

| **Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)** | |
|---|---|
| ☐ G70.00 - Myasthenia Gravis without acute exacerbation | ☐ Other: |
| ☐ G70.01 - Myasthenia Gravis with acute exacerbation | |

| **Required Documentation: (*required prior to scheduling*)** | |
|---|---|
| Patient Demographic Sheet | If the patient is new to the ordered therapy, indicate washout from previous therapy: |
| Copy of Insurance Card (front and back) | |
| Most Recent Labs (*must include labs pertinent to medication ordered*) | ☐ No Washout Needed |
| Consult Note or last 2 Office Visits with referring provider or APP | If the patient is currently on the therapy, indicate date of last infusion: |
| Complete Medication List - Include all tried and failed meds | Next infusion due date: |
| | If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request. |
| Diagnostic Studies Pertinent to Medication Ordered | ☐ Yes ☐ No |

**Labs:**

☐ POC HCG Qualitative, Urine Every Visit

**Treatment Parameters:**

☑ Hold Treatment and Notify Provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Required Lab Results: Hep B Profile (to include a Hep B Surf AG and Hep B Core AB) and PPD/Quantiferon Gold within 90 days PRIOR to FIRST treatment (**Fax labs with order**)

☑ Hold Treatment and Notify Provider IF:
- Hep B Profile: ABNORMAL or not on file;
- PPD/Quantiferon Gold: POSITIVE or not on file.

☑ Required lab result: Pregnancy Test PRIOR to infusion for all females of reproductive potential.
Hold Treatment and Notify Provider IF:
-Pregnancy test is POSITIVE or not on file.

**Nursing Communication:**

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Notify the provider IF patient is breastfeeding. Imaavy is excreted in human colostrum and breastmilk based on limited data from an investigational study.

☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.

☑ Because Imaavy causes transient reduction of IgG levels, vaccination with live vaccines is not recommended during treatment with Imaavy.

☑ Monitor patient for signs of reaction for 30mins after each infusion.

**Pre-Medications: (Administer all pre-medications 30mins prior to treatment)**

☐ Acetaminophen (Tylenol) 1000mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg IV ONCE
☐ Loratadine (Claritin) 10mg PO ONCE
☐ Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE

**Infusion Therapy: (Check all appropriate boxes)**

☐ Nipocalimab-aahu (Imaavy) 30mg/kg IV over 30 minutes Week 0
☐ Nipocalimab-aahu (Imaavy) 15mg/kg IV over 15 minutes Week 2, then every 2 weeks

**Supportive Care Medications:**

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6).
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

**Hypersensitivity Protocol:**

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

| **Prescriber Information:** | |
|---|---|
| Provider Name: | Phone: Fax: |
| Practice Name: | NPI: |
| Address: | Office Contact: |
| City, State, Zip: | Office Contact Phone Number: |

| **Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted** | |
|---|---|
| Signature: | Date: |