imaavy™ (nipocalimab-aahu)

Horizon Infusions

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____

Choose Location _____

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ Gender ☐M ☐F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION

☐ gMG (AChR or MuSK antibody positive) ICD 10 Code (_____)

☐ Warm Autoimmune Hemolytic Anemia (wAIHA) ICD 10 Code (_____)

PRESCRIPTION INFORMATION (*valid for 12 months*)

Imaavy

DOSING

☐ Initial: 30mg/kg over 30 minutes

☐ Maintenance Q2 weeks after initial dose: 15mg/kg over 15 minutes

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS

☐ Acetaminophen _____ mg

☐ Fexofenadine (Allegra) 180mg (or other non-sedating antihistamine)

☐ Diphenhydramine (Benadryl) _____

☐ Methylprednisolone (Solu-Medrol) _____

☐ Prednisone _____ mg PO

☐ Other _____

POST-MEDICATIONS

☐ Acetaminophen _____ mg

☐ Prednisone _____ mg PO

☐ Other _____

LABS

☐ CBC w/ Diff	☐ Each infusion	☐ Other frequency	_____
☐ CRP	☐ Each infusion	☐ Other frequency	_____
☐ CMP	☐ Each infusion	☐ Other frequency	_____
☐ ESR	☐ Each infusion	☐ Other frequency	_____
☐ Hepatic Panel	☐ Each infusion	☐ Other frequency	_____
☐ Renal Panel	☐ Each infusion	☐ Other frequency	_____

☐ Quantiferon TB Gold, annually, last completed*(date)*: _____

☐ Other (*specify*): _____

_____ _____

Provider Signature Date

Fax Referrals to:

Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586