

IMAAVY (nipocalimab-aahu) Infusion OrderPatient Name: _____ DOB: _____ ☐ Male ☐ Female

Diagnosis (please provide ICD10 code) _____

☐ Other: _____☐ NKDA Allergies: _____☐ New Start Therapy☐ Continuation of Therapy

Date of last dose (if applicable): _____

Ordering Provider: _____

Provider NPI: _____

Phone: _____

Fax: _____

Practice Address: _____

City: _____

State: _____

Zip Code: _____

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Diphenhydramine 25mg PO ☐ Solu-Cortef 100mg IVP
☐ Ceterizine 10mg PO ☐ Diphenhydramine 25mg IVP

REQUIRED LABS

- ☒ Clinical/Progress Notes, Labs, Tests supporting
primary diagnosis (please attach) (please attach
results)

IMAAVY ORDERS**DOSING:**

- ☐ Initial dose: 30 mg/kg administered via intravenous infusion once over at least 30 minutes
☐ Maintenance dose: 15 mg/kg administered via intravenous infusion over at least 15 minutes 2 weeks following
initial dose. Continue the maintenance dosage every two weeks thereafter.

☐ Other: _____☐ Pt weight: _____☐ **REFILLS:**

(if not indicated prescription will expire one year
from date signed)

Sage Infusion Standing Orders:

- ☒ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines,
and Action Plan for Infusion Reactions.

Provider Name_____
Provider Signature_____
Date