

# Imaavy™ (nipocalimab-aahu) Referral Form



**Preferred Clinic** (select one):

## PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

|                         |                     |                      |
|-------------------------|---------------------|----------------------|
| DOB:                    | Patient Name:       | Patient Phone:       |
| Patient Address:        | Patient Email:      |                      |
| NKDA Allergies:         | Weight (lbs/kg):    | Height:              |
| ICD-10 Code (required): | ICD-10 Description: | Last Treatment Date: |
|                         |                     | Last 4 Digits SSN:   |

## PROVIDER INFORMATION

|                                        |                             |        |           |
|----------------------------------------|-----------------------------|--------|-----------|
| Referral Coordinator Name:             | Referral Coordinator Email: |        |           |
| Ordering Provider:                     | Provider NPI:               |        |           |
| Referring Practice Name:               | Phone:                      | Fax:   |           |
| Practice Address:                      | City:                       | State: | Zip Code: |
| Physician Preferred Method of Contact: | Email:                      | Fax:   | Phone:    |

## STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

CBC w/ diff every \_\_\_\_\_

CMP every \_\_\_\_\_

OTHER \_\_\_\_\_

*\*\*Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

## PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25 mg 50 mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## IMAAVY ADMINISTRATION

30 mg/kg IV x 1 dose, followed by 15 mg/kg every 2 weeks beginning 2 weeks after first dose

15 mg/kg IV every 2 weeks

## REQUIRED DOCUMENTATION

**Patient Demographics**

**Insurance Card/Information**

**Progress Notes Supporting DX**

**Current Medication List and H&P**

**Lab results showing positive AChR or MuSK antibody**

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. \*\*Order is valid for one year unless otherwise noted\*\*

Provider Name (Print)

Provider Signature

Date

Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679

Michigan: 833-957-2188

New York: 800-540-1852

Texas: 469-340-0044

Connecticut: 203-724-4838

Minnesota: 763-290-0903

Ohio: 216-400-0674

Virginia: 804-500-5941

Florida: 904-930-4211

Nevada: 702-489-5744

Oklahoma: 918-770-4421

Wisconsin: 414-600-5383

Massachusetts: 781-202-1629

New Jersey: 609-955-3711

Pennsylvania: 215-399-9244

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