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ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

IMAAVY IV ORDERS

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐NKDA Allergies:			

PHYSICIAN INFORMATION

Physician Name:	Practice Name:	
NPI:	Office Contact Name:	Office Contact #:
Phone: Fax:	Email (for updates):	

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

Name of Medication: IMAAVY

INDICATIONS AND USAGE IMAAVY is indicated for the treatment of generalized myasthenia gravis (gMG) in adult and pediatric patients 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive

☐ **ICD-10*:** _____

PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000mg ☐other _____

☐ Solumedrol 125mg IV ☐other _____

☐ Benadryl ☐25mg ☐50mg ☐other _____ ☐IV ☐PO

☐ Medication _____ Dose _____Route _____

☐ _____ *(other)* ☐ _____ *(other)*

WARNINGS AND PRECAUTIONS

https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/IMAAVY-pi.pdf

IMAAVY ORDERS

☐ Initial dosage of IMAAVY is 30 mg/kg administered once then

☐ Maintenance dosage of IMAAVY 15 mg/kg every 2 weeks

☐ x 1 year after initial dose (unless otherwise specified)

☐ X _____ doses

PT WEIGHT

_____ kg

_____ lbs

NOTES/ADDITIONAL COMMENTS:
LAB DRAW REQUEST:

☐ Labs:_____

☐ Freq:_____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Recent Labs

_____ Recent Progress and Vaccination Status

_____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____

Order/dosage: _____

Signature: _____