

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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: _____