Nipocalimab-aahu (Imaavy)

IVX HEALTH

Provider Order Form *rev. 2/4/26*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation

NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

APPEALS PROCESS

Upon denial, IVX will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

THERAPY ADMINISTRATION

☑ **Nipocalimab-aahu (Imaavy)** in 0.9% Sodium Chloride, IV infusion
Patients ≥ 40kg: total infusion volume is 250mL
Patients <40kg: total infusion volume is 100mL

Please indicate if both induction and maintenance doses are needed:

☐ **Induction:**
- Dose: 30mg/kg
- Frequency: once at week 0
- Route: intravenous
- Infuse over 30 minutes with a 0.2-micron filter.

(maintenance doses will be given every 2 weeks thereafter)

☐ **Maintenance:**
- Dose: 15mg/kg
- Frequency: every 2 weeks beginning at week 2
- Route: intravenous
- Infuse over 15 minutes with a 0.2-micron filter.

☑ Flush with 0.9% sodium chloride at infusion completion
☑ Patient is required to stay for 30-minute observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

IVX HEALTH FAX NUMBERS

☐ ARKANSAS: 501-451-5644	☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ MELBOURNE: 321-800-9515	☐ PHILADELPHIA: 844-820-9641
☐ AUSTIN: 512-772-2824	☐ COLLEGE STN: 979-205-4686	☐ FT. WAYNE: 260-369-2310	☐ MIAMI: 786-744-5687	☐ PIEDMONT TRIAD: 336-790-2200
☐ BAY AREA: 844-889-0275	☐ COLUMBUS: 844-627-2675	☐ HARRISBURG: 844-859-4235	☐ MIDDLE/WEST TN: 888-615-1445	☐ RALEIGH: 919-287-2551
☐ CENTRAL JERSEY: 640-252-6633	☐ CONNECTICUT: 860-955-1532	☐ HOUSTON: 832-631-9595	☐ NC FL: 352-756-4191	☐ SAN ANTONIO: 726-238-9950
☐ CHARLOTTE: 336-663-0143	☐ COOKEVILLE: 931-479-1395	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH JERSEY: 551-227-2823	☐ SARASOTA: 941-870-6550
☐ CHICAGO: 312-253-7244	☐ DALLAS: 469-947-6114	☐ JACKSONVILLE: 904-212-2338	☐ NYC: 332-334-0809	☐ SOUTH JERSEY: 856-519-5309
	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ ORANGE COUNTY: 949-590-4554	☐ SOUTHWEST FL: 813-283-9144
	☐ DELAWARE: 302-596-8553	☐ LAKELAND: 863-316-3910	☐ ORLANDO: 844-946-0867	☐ TAMPA: 844-946-0849
	☐ EAST TN/TRI-CITIES: 615-425-7427	☐ LONG ISLAND: 363-201-6975	☐ PALM BEACH: 561-768-9044	☐ WACO: 254-343-7650