

# McLeod Health

## Nipocalimab-aahu (IMAAVY) Treatment Plan

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Allergies: \_\_\_\_\_

Patient Primary Phone Number: \_\_\_\_\_

### Diagnosis (select one):

- G70.00 Myasthenia Gravis without acute exacerbation
- G70.01 Myasthenia Gravis without acute exacerbation
- Other: ICD 10 Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

### Drug Orders:

- Induction: Nipocalimab-aahu (IMAAVY) (J9256) 30 mg/kg diluted in NS once via IV infusion over 30 minutes, then in two weeks give 15 mg/kg diluted in NS via IV infusion over at least 15 minutes
  - Weight less than 40 kg = 100 mL NS; weight greater than or equal to 40 kg = 250 mL NS
- Maintenance: Nipocalimab-aahu (IMAAVY) (J9256) 15 mg/kg diluted in NS via IV infusion over at least 15 minutes every two weeks
  - Weight less than 40 kg = 100 mL NS; weight greater than or equal to 40 kg = 250 mL NS
  - Order Duration: One year unless otherwise specified (Other: \_\_\_\_\_)

### Standing Orders:

- Monitor the patient for 30 minutes after each infusion for signs and symptoms of an infusion-related or hypersensitivity reaction.
- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion/injection will be stopped and physician notified.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Pre-Screening Requirements:**

- Labs to confirm diagnosis: either anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.
- For new patient referrals, please send history and physical and most recent physician note with completed plan.

**Previous Therapies:**

- Please send a complete and recently updated medication list, along with tried and failed therapies for myasthenia gravis.
- If patient has previously received nipocalimab at another facility, please provide last date received: \_\_\_\_\_
- If patient has previously received another biologic therapy, please provide the name: \_\_\_\_\_  
the last date received: \_\_\_\_\_ and the required washout from previous therapy: \_\_\_\_\_

**Additional Information**

- Patient's may be ineligible to receive nipocalimab if receiving antibiotics for active infective processes, antifungal therapy, fever and/or suspected infection and/or planned surgery.

**Insurance Information:**

Insurance Plan Name: \_\_\_\_\_

Insurance Identification Number: \_\_\_\_\_

Insurance Customer Service Contact Number: \_\_\_\_\_

**Preferred Treatment Location**

- McLeod Regional Medical Center (Florence)     McLeod Health Loris     McLeod Health Cheraw  
 McLeod Health Seacoast (Little River)     McLeod Health Dillon     McLeod Health Clarendon (Manning)

**Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at [medicationaccessteam@mcleodhealth.org](mailto:medicationaccessteam@mcleodhealth.org).**