Imaavy Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:
- ◯ G70.00 Myasthenia Gravis without Exacerbations
- ◯ G70.01 Myasthenia Gravis with Acute Exacerbation
- ◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

IMAAVY ORDER

Imaavy Dose:

- ◯ Initial Dosing: **30 mg/kg** IV infusion Day 0 over at least 30 minutes
- ◯ Maintenance Dosing: **15 mg/kg** IV Infusion every 2 weeks for _____ doses over at least 15 minutes

◯ Yes ◯ No Patient has received a live vaccine within the last 2 weeks

Premedications:

Date of last Imaavy Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____