InfuCare Rx®

Imaavy® Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
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www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ G70.00 Myasthenia Gravis without (acute) exacerbation
☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ Positive serologic test for anti-AChR antibody for gMG ☐ MG-ADL Score: _____
☐ Positive serologic test for anti-MuSK antibody for gMG ☐ MGFA classification: _____
☐ D59.11 Warm Autoimmune Hemolytic Anemia (wAIHA)
☐ Positive Direct Antiglobulin Test (DAT) / Coombs test ☐ Active Hemolysis
☐ Elevated Lactate Dehydrogenase (LDH) ☐ Elevated indirect bilirubin
☐ Deceased or absent haptoglobin ☐ Increased reticulocytes ☐ Hgb < 10g/dL

☐ Clinical/Progress notes with supporting diagnosis ☐ H&P
☐ Patient's demographics, including insurance information
☐ Please attach original prescription orders
☐ Current medications: _____
Previous therapies: ☐ eculizumab ☐ rituximab ☐ IVIG
☐ oral corticosteroids ☐ non-steroidal ISTs
☐ Previous live vaccine: _____ Date: _____

MEDICAL HISTORY

Patient Weight: _____ ☐ kg ☐ lbs
Height: _____ ☐ cm ☐ in
Allergies: _____
Therapy Start Date: _____
Therapy End Date: _____

Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary:
☐ Yes
☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated

PRESCRIPTION INFORMATION

Indication:	Directions:
MG	**Initial Dose:** ☐ 30mg/kg IV over at least 30 minutes **Subsequent Dose:** ☐ 15mg/kg IV over at least 15 minutes starting 2 weeks, every 2 weeks thereafter. Dispense 2 doses with ___ refills
wAIHA	**Initial Dose:** ☐ 30 mg/kg IV over at least 30 minutes **Subsequent Dose:** ☐ 30 mg/kg IV over at least 15 minutes every 4 weeks thereafter. Dispense 2 doses with ___ refills
Requires 30 minute post observation after each infusion	

ORDERS/OTHER MEDICATIONS

► **Orders are initiated:**
► Infusion supplies as per protocol
► Anaphylaxis Kit orders as per protocol

Flush Protocol:
► NaCl 0.9% 10mL
► Before and after infusion

☐ Other: _____

ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____

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