Please fax all pages of completed form to your drug therapy team at 866.233.7151.
To reach your team, call toll-free 866.820.4844.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Imaavy™

EVERNORTH HEALTH SERVICES

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Insurance company _____ Phone _____

Insured's name _____ Insured's employer _____

Relationship to patient _____ Identification # _____ Policy/group # _____

Prescription card: ☐ Yes ☐ No If yes, carrier _____ Policy # _____ Group #: _____

Is patient eligible for Medicare? ☐ Yes ☐ No Does patient have secondary insurance? ☐ Yes ☐ No

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact email _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Infusion location: ☐ Patient's home ☐ Office ☐ Infusion clinic Infusion clinic address: _____

Infusion clinic contact _____ Phone _____ Email address _____

3 Clinical Information

CHECK ONE

ICD-10 code (REQUIRED): ☐ G70.00 Myasthenia gravis without (acute) exacerbation ☐ G70.01: Myasthenia gravis with (acute) exacerbation

☐ **Other** _____

MG-ADL* score (if known) _____ Is your patient new to therapy? ☐ Yes ☐ No

Other drugs used to treat the disease _____

Weight _____ kg/lbs Height _____ cm/in Date recorded _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Adverse reactions with previous MG treatments? _____

If so, what MG treatment caused the reaction? _____

*Myasthenia Gravis Activities of Daily Life

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Route	Strength/Formulation	Directions
Imaavy™	IV	185 mg/mL single-dose vial	**Loading dose at Week 0:** Infuse 30mg/kg OR _____ mg intravenously once over at least 30 minutes rounding to an easily measurable dose when clinically appropriate. **Maintenance dose:** Infuse 15mg/kg OR _____ mg intravenously over at least 15 minutes every 2 weeks thereafter rounding to an easily measurable dose when clinically appropriate.

Dilution Instructions: Withdraw total volume of Imaavy and inject in an infusion container containing 0.9% sodium chloride injection. Sodium chloride dilution volume to use is weight-based as below:

Patient Weight	Sodium Chloride 0.9% Volume
40kg or greater	250mL
Less than 40kg	100mL

☐ Other instructions _____

Adverse reaction medications: *(keep on hand at all times)*

- Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe times one dose

For pediatric patients, the following weight- and age-based dosing range will be used:
<9kg and/or <2 years old: Diphenhydramine 1mg/kg up to max of 6.25mg times one dose
2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg times one dose
6–12 years old: Diphenhydramine 12.5mg to 25mg times one dose

Flushing orders:

- 0.9% Normal Saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency
- Heparin 10 units per mL 3mL intravenous (peripheral line maintained >1 day) as needed for final flush
- Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush
- May flush with 20mL Normal Saline post infusion to clear drug from line

Supplies: *(please strike through if not required)*
Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Quantity/Refills: Dispense one month supply. First month of therapy will include one loading dose plus one maintenance dose. Refills x 1 year unless noted otherwise.

☐ Other _____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

EVERNORTH HEALTH SERVICES

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