

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

Diagnosis Myasthenia gravis (without acute exacerbation) (g70.00)
 Other _____

Allergies NKDA _____

Medication instructions

Pre-medications N/A
 Provider prescribed: _____

Medication order

Dose	Frequency
<input type="checkbox"/> Less than 50 kg = 420 mg/3 mL	<input type="checkbox"/> Once a week every 6 weeks
<input type="checkbox"/> 51–99 kg = 560 mg/4 mL	<input type="checkbox"/> Other _____
<input type="checkbox"/> Greater than 100 kg = 840 mg/6 mL	
<input type="checkbox"/> Other _____	

Medication route Subcutaneous injection
 Other _____

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:
 N/A

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics

Please send to Columbia, MD Silver Spring, MD Bowie, MD Frederick, MD

Referring provider information

Referring provider name _____ NPI _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____