SPRINGSIDE INFUSION

Soliris

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis

☐ Myasthenia gravis (without acute exacerbation) (g70.00)
☐ Myasthenia gravis with acute exacerbation (g70.01)
☐ Neuromyelitis optica spectrum disorder (g36.0)
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications

☐ N/A
☐ Provider prescribed: _____

Medication order

Dose

☐ Initial: 900 mg weekly x4, 1200 mg weekly x1, then 1200 mg every 2 weeks thereafter
☐ Maintenance: 200 mg every 2 weeks
☐ Other _____

Frequency

N/A
☐ Other _____

Medication route

☐ IV
☐ 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 | Documentation of meningitis vaccine (at least 2 weeks before 1st infusion)

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 _____