

**Patient information**

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs**Diagnosis**  Generalized myasthenia gravis (gmg) in adult and pediatric patients 12 years of age and holder who are anti-acetylcholine receptor (achr) or anti-muscle-specific tyrosine kinase (musk) antibody positive. ICD 10: g70.0 Other \_\_\_\_\_**Allergies**  NKDA  \_\_\_\_\_**Medication instructions****Pre-medications**  N/A Provider prescribed: \_\_\_\_\_**Medication order**

Dose

 Initial dose: 30mg/kg, then 15mg/kg and continue 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

**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 \_\_\_\_\_