

**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)  
 Paroxysmal nocturnal hemoglobinuria (pnh) (d59.5)  
 Atypical hemolytic uremic syndrome (ahus) (d59.3)  
 Other \_\_\_\_\_

**Allergies**  NKDA  \_\_\_\_\_

**Medication instructions**

**Pre-medications**  N/A  
 Provider prescribed: \_\_\_\_\_

**Medication order**

<b>Dose</b>	<b>Frequency</b>
<input type="checkbox"/> Pt weight 40-59kg: 2,400 mg on week 0 and 2, then 3,00mg every 8 weeks	<input type="checkbox"/> Week 0, 2, then every 8 weeks
<input type="checkbox"/> Pt weight 60-99kg: 2,700 mg on week 0 and 2, then 3,000mg every 8 weeks	<input type="checkbox"/> Every 8 weeks
<input type="checkbox"/> Pt weight 100kg or more: 3,000 mg on week 0 and 2, then 3,600mg every 8 weeks	<input type="checkbox"/> Other _____
<input type="checkbox"/> 1200 mg (uc) - IV	
<input type="checkbox"/> 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 | Proof of meningococcal vaccination at least 2 weeks prior to start of treatment

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