

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

Diagnosis Neuromyelitis optica spectrum disorder (g36.0)
 Immunoglobulin g4-related disease (lgg4-rd) in adult patients (d89.84)
 Other _____

Allergies NKDA _____**Medication instructions**

Pre-medications N/A
 Provider prescribed: _____

Medication order Dose Frequency
 300 mg Initial: weeks 0 and 2, then every 6 months
 Other _____ (starting 6 months from 1st infusion)
 Subsequent: every 6 mos
 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 | Negative Hep B | Negative TB

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 _____