

### 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)  
 Chronic inflammatory demyelinating polyneuropathy (cidp) (g61.81)  
 Other \_\_\_\_\_

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

### Medication instructions

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

Medication order      Dose      Frequency  
 10 mg/kg (if patient weighs less than 120 kg)       Every 4 weeks  
 1200 mg (if patient weighs 120 kg or more)       Other \_\_\_\_\_  
 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 \_\_\_\_\_