SPRINGSIDE
INFUSION

Vyvgart Hytrulo

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
☐ Xx mg
☐ Xxx mg
☐ Xxxx mg
☐ Other __________________________

Frequency
☐ Every x weeks
☐ Other __________________________

Medication route
☐ Subcutaneous injection
☐ 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 ______________________

© Springside Infusion, Inc.