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Somerset, NJ 08873

Long Branch
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127 Church Road
Suite 600
Marlton, NJ 08053

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

Burosumab-twza (Crysvita)
Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

PRE-MEDICATION ORDERS

- ☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV
- ☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
- ☐ Other: _____
  Dose: _____ Route: _____
  Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- ☐ **Burosumab-twza** (Crysvita) subcutaneous injection
- ☐ Pediatric patients less than 10kg
  - Dose: 1mg/kg (Rounded to the nearest 1mg)
  - Other ☐ _____mg/kg
  - ☐ Frequency: every two weeks ☐ Other _____
- ☐ Pediatric patients 10kg and greater
  - Dose: 0.8mg/kg (Rounded to the nearest 10mg. Max dose90mg.)
  - Other _____mg/kg
  - ☐ Frequency: every two weeks ☐ Other _____
- ☐ Adult patients (18 years and older)
  - Dose: 1mg/kg (Rounded to the nearest 10mg. Max dose of 90mg.)
  - Other _____mg/kg
  - ☐ Frequency: Every four weeks ☐ Other _____

  Route: ☐ subcutaneous (maximum volume per injection is 1.5ml. If multiple injections are required, administer at different injection sites)
- ☐ Patient is required to stay for 30-minute observation post infusion/injection
- ☐ Patient is NOT required to stay for observation time
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
  (if not indicated order will expire one year from date signed)

☐ Total Doses_____ ☐Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____