

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



Burosumab-twza (Crysvita) Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO <input type="checkbox"/> cetirizine (Zyrtec) 10mg PO <input type="checkbox"/> loratadine (Claritin) 10mg PO <input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV <input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV <input type="checkbox"/> Other: _____ Dose: _____ Route: _____ Frequency: _____
SPECIAL INSTRUCTIONS
<div style="border: 1px solid black; height: 150px; width: 100%;"></div>

THERAPY ADMINISTRATION
<input type="checkbox"/> Burosumab-twza (Crysvita) subcutaneous injection <input type="checkbox"/> Pediatric patients less than 10kg • Dose: 1mg/kg (Rounded to the nearest 1mg) • Other <input type="checkbox"/> _____mg/kg <input type="checkbox"/> Frequency: every two weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Pediatric patients 10kg and greater • Dose: 0.8mg/kg (Rounded to the nearest 10mg. Max dose 90mg.) • Other _____mg/kg <input type="checkbox"/> Frequency: every two weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Adult patients (18 years and older) • Dose: 1mg/kg (Rounded to the nearest 10mg. Max dose of 90mg.) • Other _____mg/kg <input type="checkbox"/> Frequency: Every four weeks <input type="checkbox"/> Other _____ Route: <input type="checkbox"/> subcutaneous (maximum volume per injection is 1.5ml. If multiple injections are required, administer at different injection sites) <input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion/injection <input type="checkbox"/> Patient is NOT required to stay for observation time <input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed) <input type="checkbox"/> Total Doses _____ <input type="checkbox"/> Refills _____

NOTES/ADDITIONAL COMMENTS:
<div style="border: 1px solid black; height: 80px; width: 100%;"></div>

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____