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

Mission Medical

(Crysvita)

Burosumab-twza

Infusion orders

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:

DIAGNOSIS *(and ICD 10 code)*

- ☐ XLH: (familial hypophosphatemia) ICD-10 Code: E83.31
- ☐ TIO: other adult osteomalacia ICD-10 Code: M83.8
- ☐ Other disorders of phosphorus metabolism ICD-10 Code: E83.39

NOTE

List Tried & Failed Therapies, including duration of treatment:

1)
2)

**Referring physician is responsible for monitoring and reviewing the following labs prior to treatment:

• Fasting phosphorus level prior to each dose for first 3 doses and administer only if below ULN

• Fasting phosphorus level 2-4 weeks after dose modifications If dose adjustments are needed, new order must be sent by provider based on PI dose calculations

Burosumab-twza ORDERS

Indication

- ☐ Pediatric XLH (6 months and older)
- ☐ Adult XLH
- ☐ Pediatric TIO 2 years and older
- ☐ Adult TIO
- ☐ *Adult TIO

Medication(check one)

- ☐ Crysvita less than 10 kg
- ☐ Crysvita greater than 10 kg
- ☐ Crysvita

Dosing

- ☐ 1 mg/kg SQ rounded to the nearest 1 mg max 90 mg
- ☐ 0.8 mg/kg SQ rounded to the nearest 10 mg max 90 mg
- ☐ 1 mg/kg SQ rounded to the nearest 10 mg max 90 mg
- ☐ 0.4 mg/kg SQ rounded to the nearest 10 mg
- ☐ 2 mg/kg not to exceed 180 mg
- ☐ 0.5 mg/kg not to exceed 180mg
- ☐ _____mg/kg (dose may be increased up to 2mg/kg not to exceed 180mg administered every 2weeks)

Frequency

- ☐ Every 2 weeks
- ☐ Every 4 weeks
- ☐ Every _____ weeks

Refills*: None ☐X6 months ☐X1 year ☐Other: _____

**(if not indicated order will expire one year from date signed)*

REQUIRED DOCUMENTATION:

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Clinical/Progress notes supporting primary diagnosis
- ☐ Documentation that pt has stopped phos meds and Vit D
- ☐ Fasting serum phosphorus concentration should be below the reference range for age prior to initiation of treatment

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____