

(Crysvita)

Burosumab-twza

Infusion orders

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: _____

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 _____