Palmetto INFUSION

MRN:_____________________

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB: ____________________

STANDARD Crysvita (Burosumab-twza) PLAN OF TREATMENT FOR ADULT PATIENTS

NOTE: Patient ***may be ineligible*** to receive Crysvita with elevated phosphorus serum levels .

1. Patient Name:___________________________________Height (inches):_____Weight (lbs):_____

2. Allergies: ____

3. Diagnosis: * **Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ E83.31 Familial Hypophosphatemia ☐ Other **ICD-10 Code:**________**Diagnosis**_________________

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4. Orders: CRYSVITA – Starting dose is 1mg/kg rounded to the nearest 10mg administered every 4 weeks. The maximum dose is 90mg.

Dosing Adjustment:

*__Do not adjust CRYSVITA dosing more frequently than every 4 weeks.__

Dose Decrease: If serum phosphorus level is above normal range, withhold the next dose and reassess level after 4 weeks. The patient must have a serum phosphorus level below the normal range to reinitiate Crysvita. Once the serum phosphorus is below the normal range treatment may be restarted at approximately half the initial starting dose up to a maximum of 40mg every 4 weeks according to the dose schedule in the TABLE below.

Previous Dose (mg)	Re-Initiation Dose (mg)
40	20
50	20
60	30
70	30
80 and greater	40

(Administer subcutaneous injections only to upper arm, upper thigh, buttocks, or abdomen. Do not give more than 1.5ml per injection site)

Clinical Lab Monitoring: ***Referring physician will be responsible for obtaining and monitoring labs. Monitor* fasting *serum phosphorus levels monthly, measured 2 weeks post-dose, for first 3 months of therapy and thereafter as appropriate. Reassess serum phosphorus level 2 weeks after any dose adjustment.***

Special orders: ____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.

5. Physician's Signature:_________________________/______________________Date: ______________

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:____NPI: __________________

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

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Guidelines for Prescribing Crysvita (Burosumab-twza)

(Required documentation with all initial referrals)

Patient Name:____ **Referral Date:** ____________________

____ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

____ Include patient demographic information and insurance information. (Copy of insurance cards if available)

____ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

____ Other as requested: ____

Pre-Screening:

____ Serum Phosphorus level required **(**Serum level must be below normal range for age to initiate treatment.)

____ Discontinue oral phosphate and active Vitamin D analogs 1 week prior to initiation of treatment. Stop date:________________

_____ Contraindicated with severe renal impairment or end stage renal disease.

---------------------------**WARNINGS AND PRECAUTIONS**--------------------

- Hypersensitivity: Discontinue CRYSVITA if serious hypersensitivity reactions occur and initiate appropriate medical treatment. (5.1)
- Hyperphosphatemia and Risk of Nephrocalcinosis: For patients already taking CRYSVITA, dose interruption and/or dose reduction may be required based on a patient's serum phosphorus levels. (5.2)
- Injection Site Reactions: Administration of CRYSVITA may result in local injection site reactions. Discontinue CRYSVITA if severe injection site reactions occur and administer appropriate medical treatment. (5.3, 6.1)

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 7/16/19, per PI4249649