



MRN: \_\_\_\_\_

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

DOB: \_\_\_\_\_

Dose Decrease: If serum phosphorus level is above 5mg/dl, withhold the next dose and reassess the level in 4 weeks. The patient must have a serum phosphorus level below the reference range for age to reinitiate Crysvida. Once the serum phosphorus is below the reference range for age, treatment may be restarted according to the dose schedule shown in TABLE 2. If the level remains below the reference range for age after the re-initiation dose, the dose can be adjusted according to TABLE 1.

**Table 2: Pediatric Dose Schedule for Re-Initiation of Therapy**

Previous Dose (mg)	Re-Initiation Dose (mg)
10	5
15	10
20	10
30	10
40	20
50	20
60	30
70	30
80	40
90	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 serum phosphorus levels every 4 weeks for first 3 months of therapy and thereafter as appropriate. Reassess serum phosphorus level 4 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](http://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](http://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 reference 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.**