MRN:_____

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**_____

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 (Substitution

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB: _____

Guidelines for Prescribing Crysvita (Burosumab-twza)

(Required documentation with all initial referrals)

Patient Name:_____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ 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 levelrequired **(**Serum level must be below normal range for age to initiate treatment.)

☐ Discontinue oral phosphate and active Vitamin D analogs 1 week prior toinitiation of treatment. Stop date:_____

☐ Contraindicated with severe renal impairment or end stage renaldisease.

----------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)

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.