

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Crysvita® (burosumab-twza) Adult Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

E83.31 - Familial Hypophosphatemia
_____ - Other:

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1 Insurance information	IF NO:	IF YES:
2 Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3 Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4 Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5 Fasting serum phosphorus level *required*	THERAPY:	Continue current order until insurance approved
6 Discontinuation of oral phosphate and Vit D analogs 1 week prior to initiation		

MEDICATION ORDERS:

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

MEDICATION:

Crysvita® (burosumab-twza)
 (Administered as subcutaneous injection to upper arm, upper thigh, buttocks, or abdomen. Do not give more than 1.5ml per injection site.)

DOSE:

1mg/kg up to 90mg (recommended starting dose with a maximum recommended dose of 90mg)
 Other: _____

All doses will be rounded to the nearest 10mg.

FREQUENCY:


Every 4 weeks
 Other: _____

Referring physician will be responsible for obtaining and monitoring labs.

SPECIAL ORDERS:

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
---	---	---

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted