Palmetto INFUSION®

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

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Crysvita® (burosumab-twza) Pediatric 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: ☐ See list ☐ NDKA	

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

☐ E83.31 - Familial Hypophosphatemia

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS AMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Fasting serum phosphorus level *required*		☐ **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:

☐ Weight ≤ 10kg: 1mg/kg (rounded to the nearest 1mg)

☐ Weight ≥ 10kg: 0.8mg/kg up to 90mg (recommended starting dose with a maximum recommended dose of 90mg)

☐ Other: _____

All doses will be rounded to the nearest 10mg for patients with body weight > 10kg.

FREQUENCY:

☐ Every 2 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:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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	