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:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |
| 5 | Fasting serum phosphorus level *required* |
| 6 | Discontinuation of oral phosphate and Vit D analogs 1 week prior to initiation |

## PREVIOUS AMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

| IF NO: | IF YES: |
|---|---|
| PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INJECTION DATE: |
| | NEXT INJECTION DATE: |
| | **IF ORDER CHANGE:** |
| | ☐ **Continue current order until insurance approved** |

## 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:

## 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 | |