

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 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

E83.31 - Familial Hypophosphatemia	E83.8 Other adult osteomalacia
E83.39 - Other disorders of phosphorus metabolism	
- 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	<b>IF ORDER CHANGE:</b>
5 Fasting serum Phosphorus level *required*	THERAPY:	
6 Discontinuation of oral phosphate and Vit D analogs 1 week prior to initiation		
		<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

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

#### MEDICATION:

Crysvita<sup>®</sup> (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:

### 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



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)