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	☐ NKDA

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

☐	E83.31 - Familial Hypophosphatemia	☐	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 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	**NOTE: 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. Concomitant use of burosumab-twza with oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol) due to the risk of hyperphosphatemia.

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: _____

LAB PARAMETERS: (Physician responsible for all follow up lab monitoring)

Recommendations:

- Therapy Initiation: Draw fasting serum phosphorus every 4 weeks for first 3 month of treatment
- Hold medication if serum phosphorus is above 5 mg/dL, redraw levels in 4 weeks, reassess and restart dosing according to package labeling.

SPECIAL/OTHER ORDERS:

☐ Hold medication dose if fasting serum phosphous is greater than _____ and call prescriber.
☐ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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	

Palmetto INFUSION

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