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

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:					
Patient's Phone:		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.

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	