

Burosumab-twza (Crysvita)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Familial hypophosphatemia: _____ Other disorders of phosphorus metabolism: _____
Tumor Induced Osteomalacia: _____ X-linked hypophosphatemia: _____
Other diagnosis: _____

THERAPY ADMINISTRATION

Administer Crysvita _____ mg (round to nearest 10 mg) subcutaneously in the upper arm/abdomen/upper thigh. Maximum volume per site is 1.5 ml
 Following initial treatment, observe patient for 15 minutes for hypersensitivity

DOSING INFORMATION

Dosing information for Adults:
• XLH: 10mg-90mg max (usually 1mg/kg) max 90mg every 4 weeks
• TIO: 0.5mg/kg to 2mg/kg max of 180mg every 2 weeks
Dose adjustments should not occur more frequently than every 4 weeks

FREQUENCY (Choose one)

Every 2 weeks
 Every 4 weeks

LABORATORY ORDERS

Patient has been provided with lab order and instructions to assess fasting serum phosphorus on a monthly basis, measured 2 weeks post-dose, for the first 3 months of treatment, and thereafter as appropriate.

PRE-MEDICATION ORDERS

Other: _____

NURSING

Serum phosphorus at initiation of therapy: _____ mg/dL
Date: _____
 Hold infusion and notify provider for:
• Serum phosphorus within or above normal range at **initiation of therapy**
• Serum phosphorus above normal range for patients **already on therapy**
• Pt reports taking oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol) within 1 week prior to initiation of treatment
• Ensure that provider is monitoring 25-hydroxy-vitamin D levels.
• CrCl<30
 Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, radiology results

Required Labs: Genetic testing to confirm a phosphate regulating gene mutation, FGF23, phosphorus levels

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.