Burosumab-twza (Crysvita)

Provider Order Form rev. 10/30/2023

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.

☐ Other: _____

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.