

CRYSVITA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs,
Serum Phosphorous

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ E83.31 (Familial Hypophosphatemia) ☐ M83.8 (Other Adult Osteomalacia)
☐ Other: _____

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

Serum Phosphorous completed: ☐ Yes ☐ No (If yes, include labs)

TREATMENT INFORMATION

CRYSVITA (burosumab-twza)

Route: Subcutaneous Injection

Dose: ☐ 0.8mg/kg ☐ 1mg/kg

Frequency:

- ☐ Pediatric: 0.8mg/kg every 2 weeks
☐ Adult: 1mg/kg every 4 weeks

Quantity: _____ Refills: _____

Premedication Protocol: (Not Usually Indicated)

- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity
protocol established by Restore Health

Special Instructions: _____

Provider Signature: _____

Date: _____

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