

CRYSVITA

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

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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

PRESCRIBER INFORMATION

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

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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