RESTORE HEALTH
INFUSION AND WELLNESS

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: _____