

CRYSVITA (BUROSUMAB-TWZA) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

X-linked Hypophosphatemia, ICD 10: E83.31

Tumor-induced Osteomalacia, ICD 10: M83.3

Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO

Famotidine 20 mg IV

Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO

Cetirizine (Zyrtec) 10 mg PO

Other: _____ Dose: _____ Route: _____

MEDICATION

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|------------|----------------------------------|---|--|
| Crysvita | <input type="checkbox"/> 1 mg/kg | <input type="checkbox"/> Subcutaneous Inj | <input type="checkbox"/> Every 4 weeks |

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621 ME: 207.407.7272 NH: 603.217.5371 NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: _____