MIC | METRO INFUSION CENTER

INFUSION ORDERS- CRYSVITA® (burosumab-twza)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*

DIAGNOSIS AND ICD 10 CODE

☐ XLH: (familial hypophosphatemia) ICD 10 Code: E83.31 ☐ TIO: other adult osteomalaciaICD 10 Code: M83.8
☐ other disorders of phosphorus metabolism ICD 10 Code: E83.39

REQUIRED DOCUMENTATION/Testing

☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Documentation that pt has stopped phos meds and Vit D	☐ Clinical/Progress notes supporting primary dx ☐ Fasting serum phosphorus concentration should be below the reference range for age prior to initiation of treatment

Required labs to be done prior to treatment:
☐ Draw fasting phosphorus level prior to each dose for first 3 doses and administer only if below ULN
☐ Draw fasting phosphorus level 2-4 weeks after dose modifications

List Tried & Failed Therapies, including duration of treatment:
1) 2)

Pt Weight:_____ **MEDICATION ORDERS**

Medication	Indication	Dosing	Route	Dates of administration
☐ Cyrstvita less than 10kg	Pediatric XLH (6 months and older):	1 mg/kg rounded to the nearest 1 mg	SQ	Every 2 weeks
☐ Cyrstvita greater than 10kg		0.8 mg/kg rounded to the nearest 10 mg	SQ	
☐ Cyrstvita	Adult XLH	1 mg/kg rounded to the nearest 10 mg max 90 mg	SQ	Every 4 weeks
☐ Cyrstvita	Pediatric TIO 2 years and older	☐ 0.4 mg/kg rounded to the nearest 10 mg ☐ 2 mg/kg not to exceed 180 mg		Every 2 weeks
☐ Cyrstvita	Adult TIO	☐ 0.5 mg/kg ☐ 2 mg/kg not to exceed 180 mg	SQ	Every ____ weeks

Refills: ☐ X 6 months ☐ X 1 year ☐ _____ dose

OTHER ORDERS

If dose adjustments are needed, new order must be sent by provider based on PI dose calculations

PHYSICIAN INFORMATION

Prescribing Physician:		
Office Contact Name:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: [877] 448-3627
Send Completed Form and all documentation to:
Confidential email: Intake@Metroinfusioncenter.com or [866] 507-1164