Burosumab-twza (Crysvita)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:	DOB:	
☐ NKDA Allergies:	Weight (lbs / kg):	Height:	
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:		Next Due Date:	
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ XLH: (familial hypophosphatemia)	ICD-10 Code: E83.31		
☐ TIO: other adult osteomalacia	ICD-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 ☐ Clinical/Progress notes supporting primary dx ☐ Documentation that pt has stopped phos meds and Vit D	☐ Fasting serum phosphorus concentration should be below the reference range for age prior to initiation of treatment

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

BIOLOGIC ORDERS

Indication	Medication (check one)	Dosing	Frequency
Pediatric XLH (6 months and older):	☐ Crysvita less than 10 kg	1 mg/kg SQ rounded to the nearest 1 mg max 90mg	Every 2 weeks
	☐ Crysvita greater than 10 kg	0.8 mg/kg SQ rounded to the nearest 10 mg max 90mg	
Adult XLH	☐ Crysvita	1 mg/kg SQ rounded to the nearest 10 mg max 90 mg	Every 4 weeks
Pediatric TIO 2 years and older	☐ Crysvita	☐ 0.4 mg/kg SQ rounded to the nearest 10 mg ☐ 2 mg/kg not to exceed 180 mg	Every 2 weeks
Adult TIO	☐ Crysvita	☐ 0.5 mg/kg not to exceed 180mg	Every 4 weeks
*Adult TIO	☐ Crysvita	☐ _____mg/kg (dose may be increased up to 2mg/kg not to exceed 180mg administered every 2weeks)	Every _____ weeks

Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____

(if not indicated order will expire one year from date signed)

***Referring physician is responsible for monitoring and reviewing the following labs prior to treatment:*

- *Fasting phosphorus level prior to each dose for first 3 doses and administer only if below ULN*
- *Fasting phosphorus level 2-4 weeks after dose modifications*

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

Provider Name (Print) ****Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 1/27/23