immersiv HEALTH

CRYSVITA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ E83.31 Familial Hypophosphatemia

☐ E83.39 Other disorders of phosphorus metabolism

☐ E83.8 Other adult osteomalacia

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & failed Therapies ☐ Most recent History & Physical ☐ Fasting serum phosphorus

MEDICATION ORDER

*Patient to discontinue oral phosphate & vitamin D analogues 1 week prior to initiation of Crysvita

For Pediatric Familial Hypophosphatemia

☐ **PEDS ≥ 10 kg:** Crysvita® (burosumab) 0.8 mg/kg rounded to nearest 10 mg subcutaneously every 2 weeks

*For peds ≥ 10 kg, minimum dose of 10 mg & maximum dose of 90 mg

For Adult Familial Hypophosphatemia

☐ Crysvita® (burosumab) 1 mg/kg rounded to nearest 10 mg subcutaneously every 4 weeks

*Maximum dose of 90 mg per dose

☐ **OTHER:** _____

LAB ORDERS *PRESCRIBER RESPONSIBLE FOR ON-GOING CLINICAL LAB MONITORING

LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 15 minutes following the first injection.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN