

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. Administer per protocol.
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