

INFUSION & MEDICAL CENTER

1. _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. **Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: _____ Familial Hypophosphatemia ICD-10 Code: E83.31
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. **Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes & labs supporting primary diagnosis
- Recent lab results including baseline serum phosphorous and serum creatinine
- Medication List
 - Patients should discontinue oral phosphate and Vit D analogues by: _____

Patient Weight: _____ lbs.
Patient Height: _____ in.

Infusion Center – Lab Orders: (Check order for Infusion Center to manage):

Serum Phosphorous level at baseline and then every 4 weeks for the duration of therapy

CRYSVITA® (burosumab-twza)

J Code: J0584

4. **Drug Order:**

*****NOTE: Maximum dose 90 mg per dose *****

- Pediatric Familial Hypophosphatemia** _____ # Refills (Recommend 25 Refills)
- Peds <10 Kg: Administer 1 mg/kg rounded to the nearest 1 mg (_____ mg) subcutaneously every 2 weeks
- Peds >10 Kg: Administer 0.8 mg/kg rounded to the nearest 10 mg (_____ mg) subcutaneously every 2 weeks
- Adult Familial Hypophosphatemia** _____ # Refills (Recommend 11 Refills)
- Administer 1 mg/kg rounded to the nearest 10 mg (_____ mg) subcutaneously every 4 weeks
- Other** _____ # Refills
- Administer _____ mg/kg rounded to the nearest 10 mg (_____ mg) subcutaneously every _____ weeks

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** _____ / _____ Date: _____

Dispense as written

Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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