Fax: 832-895-4040
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adaptIV infusion

Crysvita (Burosumab-twza)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Most recent Phosphorus results (attach clinicals and list results)

_____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Burosumab-twza** (Crysvita) subcutaneous injection
☐ Pediatric patients less than 10kg
- Dose: 1mg/kg (Rounded to the nearest 1mg)
- ☐ Other _____ mg/kg

☐ Frequency: every two weeks
☐ Pediatric patients 10kg and greater
- Dose: 0.8mg/kg (Rounded to the nearest 10mg. Max dose 90mg.)
- ☐ Other _____ mg/kg

☐ Frequency: every two weeks
☐ Adult patients (18 years and older)
- Dose: 1mg/kg (Rounded to the nearest 10mg. Max dose of 90mg.)
- ☐ Other _____ mg/kg

☐ Frequency: Every four weeks
Route: ☐ subcutaneous (maximum volume per injection is 1.5ml. If multiple injections are required, administer at different injection sites)

☐ Patient required to stay for 30-min observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK