

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57 West 57 Street
Suite 601
New York, NY 10019



Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Manhattan
225 East 70th Street
New York, NY 10021

Holbrook/Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

Elmsford/ Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523



Burosumab-twza (Crysvita) Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

New Referral Referral Renewal Medication/Order Change Benefits Verification Only Discontinuation Order

PHYSICIAN INFORMATION

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

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
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

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 is required to stay for 30-minute observation post infusion/injection
 - Patient is NOT required to stay for observation time
 - Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____