

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873



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
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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 Other _____

Pediatric patients 10kg and greater

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

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 Other _____

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)

Total Doses _____ Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____