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

*Long Branch*
422 Morris Avenue
Suite 7
Long branch, NJ 07740

*Marlton*
127 Church Road
Suite 600
Marlton, NJ 08053

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

(Crysvita)

# Burosumab-twza

Infusion orders

Date: _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| ICD-10 code (required): | ICD-10 description: | |
| ☐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: |

## DIAGNOSIS *(and ICD 10 code)*

- ☐ XLH: (familial hypophosphatemia) ICD-10 Code: E83.31
- ☐ TIO: other adult osteomalacia ICD-10 Code: M83.8
- ☐ Other disorders of phosphorus metabolism ICD-10 Code: E83.39

### NOTE

**List Tried & Failed Therapies, including duration of treatment:**

1)
2)

**Referring physician is responsible for monitoring and reviewing the following labs prior to treatment:

• Fasting phosphorus level prior to each dose for first 3 doses and administer only if below ULN

• Fasting phosphorus level 2-4 weeks after dose modifications If dose adjustments are needed, new order must be sent by provider based on PI dose calculations

## Burosumab-twza ORDERS

***Indication***

- ☐ Pediatric XLH (6 months and older)
- ☐ Adult XLH
- ☐ Pediatric TIO 2 years and older
- ☐ Adult TIO
- ☐ *Adult TIO

***Medication(check one)***

- ☐ Crysvita less than 10 kg
- ☐ Crysvita greater than 10 kg
- ☐ Crysvita

***Dosing***

- ☐ 1 mg/kg SQ rounded to the nearest 1 mg max 90 mg
- ☐ 0.8 mg/kg SQ rounded to the nearest 10 mg max 90 mg
- ☐ 1 mg/kg SQ rounded to the nearest 10 mg max 90 mg
- ☐ 0.4 mg/kg SQ rounded to the nearest 10 mg
- ☐ 2 mg/kg not to exceed 180 mg
- ☐ 0.5 mg/kg not to exceed 180mg
- ☐ _____mg/kg (dose may be increased up to 2mg/kg not to exceed 180mg administered every 2weeks)

***Frequency***

- ☐ Every 2 weeks
- ☐ Every 4 weeks
- ☐ Every _____ weeks

Refills*: None ☐X6 months ☐X1 year ☐Other: _____

**(if not indicated order will expire one year from date signed)*

## REQUIRED DOCUMENTATION:

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Clinical/Progress notes supporting primary diagnosis
- ☐ Documentation that pt has stopped phos meds and Vit D
- ☐ Fasting serum phosphorus concentration should be below the reference range for age prior to initiation of treatment

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____