

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD 10 CODE

X - linked hypophosphatemia ICD-10 Code: _____
 Tumor-induced osteomalacia ICD-10 Code: _____
 Other disorders of phosphorus metabolism ICD-10 Code: _____

REQUIRED DOCUMENTATION/TESTING

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

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)

MEDICATION ORDERS

Indication		Dosing
XLH	Pediatric (>6 months) <10kg	<input type="checkbox"/> Crysvida 1 mg/kg SubQ every 2 weeks (rounded to nearest 1mg)
	Pediatric (>6 months) >10kg	<input type="checkbox"/> Crysvida 0.8 mg/kg SubQ every 2 weeks (rounded to nearest 10mg, Max 90mg)
	Adult	<input type="checkbox"/> Crysvida 1 mg/kg SubQ every 4 weeks (rounded to nearest 10mg, Max 90mg)
TIO	Pediatric (>2 years)	<input type="checkbox"/> Crysvida 0.4 mg/kg SubQ every 2 weeks (rounded to nearest 10mg)
	Adult	<input type="checkbox"/> Crysvida 0.5 mg/kg SubQ every 4 weeks (rounded to nearest 10mg)
	Pediatric or Adult	<input type="checkbox"/> Crysvida _____ mg/kg SubQ every 2 weeks (rounded to nearest 10mg, Max 180mg)
Other		<input type="checkbox"/> Crysvida _____ mg SubQ every _____ weeks _____

Refills*: X 6 months X 1 Year _____ doses Other: _____

*(if not indicated, order will expire 1 year from date signed)

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol

Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____