SPECIALTY INFUSION CENTER
An Access Infusion Care Company

CRYSVITA (BUROSUMAB-TWZA) ORDERS

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

☐ Patient demographics AND insurance information

☐ Clinical/Progress notes supporting primary diagnosis

☐ Documentation that patient has stopped phos meds and Vit D

☐ Fasting serum phosphorus concentration should be below the reference range for age prior to initiation of treatment

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

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

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

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

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