# CRYSVITA® (BUROSUMAB-TWZA) PRESCRIBER ORDER FORM

| Patient Name: | Date of Birth: | Gender: |
|---|---|---|

Address:

| Phone: | Height: | ☐ Inches ☐ cm | Weight: | ☐ lbs ☐ kg |
|---|---|---|---|---|

## Clinical Information

| Primary Diagnosis Description: | ICD-10 Code: |
|---|---|

**Allergies:** ☐ NKDA OR (List):

## CRYSVITA® (burosumab-twza) Medication Order

| **Pediatric X-linked hypophosphatemia(XLH) (6 months and older)** | |
|---|---|
| ☐ Less than 10 kg | 1 mg/kg SUBQ every 2 weeks |
| ☐ 10kg or more | 0.8mg/kg SUBQ every 2 weeks<br>Rounded to the nearest 10mg. Max 90mg |
| **Adult X-linked hypophosphatemia(XLH)** | ☐ 1 mg/kg SUBQ every 4 weeks<br>☐ 1 mg/kg SUBQ every 2 weeks<br>Rounded to the nearest 10mg. Max 90mg |
| **Pediatric Tumor-induced Osteomalacia (TIO) – 2 years of age and older** | ☐ 0.4 mg/kg SUBQ every 2 weeks<br>☐ 2 mg/kg SUBQ every 2 weeks<br>Rounded to nearest 10mg. Max 180mg |
| **Adult Tumor-induced Osteomalacia (TIO)** | ☐ 0.5mg/kg SUBQ every 4 weeks<br>☐ 2 mg/kg SUBQ every 2 weeks<br>Rounded to nearest 10mg. Max 180mg |

☐ Other: ____________________ Dispense refills x 1 year

**Anaphylaxis Kit**

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.
- Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

**Lab Orders**

☐ No labs ordered at this time.

☐ Other: ____________________

Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy and skilled nursing plan of treatment will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

**Prescriber Signature:** ____________________ **Date:** __________

## Prescriber Information

| Prescriber Name: | Phone: | Fax: |
|---|---|---|
| Address: | NPI: | |
| City, State: | Zip: | Office Contact: |

**Fax completed form, insurance information, and clinical documentation to: (713) 983-4647**

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