Crysvita (burosumab-twza)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ M90.80 X-linked hypophosphatemia (XLH)
☐ M83.8 Adult osteomalacia
☐ E83.31 X-linked hypophosphatemia (XLH), familial hypophosphatemia
☐ E83.39 (other disorders of phosphorus metabolism)
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☑ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Creatinine and Phosphorus
☐ Other: _____

Crysvita (burosumab-twza) SC (Select one):

☐ **Pediatric XLH (6 months and older):**
☐ Less than 10 kg: Inject 1 mg/kg SQ, rounded to the nearest 1 mg, max 90 mg every 2 weeks
☐ Greater than 10 kg: Inject 0.8 mg/kg SQ, rounded to the nearest 10 mg, max 90 mg every 2 weeks

☐ **Pediatric TIO (2 years and older):**
☐ Inject 0.4 mg/kg SQ, rounded to the nearest 10 mg, every 2 weeks
☐ Inject 2 mg/kg SQ, do not exceed 180 mg, every 2 weeks

☐ **Adult XLH:**
☐ Inject 1 mg/kg SQ, rounded to the nearest 10 mg, max 90 mg, every 4 weeks

☐ **Adult TIO:**
☐ Inject 0.5 mg/kg SQ, Do not to exceed 180mg, every 4 weeks
☐ _____mg/kg (dose may be increased up to 2mg/kg) Every _____ weeks Do not to exceed 180mg administered every

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454