Burosumab-twza (Crysvita)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Familial hypophosphatemia: Other disorders of phosphorus metabolism:

Tumor Induced Osteomalacia: X-linked hypophosphatemia:

Other diagnosis:

THERAPY ADMINISTRATION

☑ Administer Crysvita _____ mg (round to nearest 10 mg) subcutaneously in the upper arm/abdomen/upper thigh. Maximum volume per site is 1.5 ml

☑ Following initial treatment, observe patient for 15 minutes for hypersensitivity

DOSING INFORMATION

Dosing information for Adults:

- XLH: 10mg-90mg max (usually 1mg/kg) max 90mg every 4 weeks
- TIO: 0.5mg/kg to 2mg/kg max of 180mg every 2 weeks

Dose adjustments should not occur more frequently than every 4 weeks

FREQUENCY *(Choose one)*

☐ Every 2 weeks

☐ Every 4 weeks

LABORATORY ORDERS

☑ Patient has been provided with lab order and instructions to assess fasting serum phosphorus on a monthly basis, measured 2 weeks post-dose, for the first 3 months of treatment, and thereafter as appropriate.

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Serum phosphorus at initiation of therapy: _____ mg/dL Date: _____

☑ Hold infusion and notify provider for:

- Serum phosphorus within or above normal range at ***initiation of therapy***
- Serum phosphorus above normal range for patients ***already on therapy***
- Pt reports taking oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol) within 1 week prior to initiation of treatment
- Ensure that provider is monitoring 25-hydroxy-vitamin D levels.
- CrCl<30

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, radiology results

Required Labs: Genetic testing to confirm a phosphate regulating gene mutation, FGF23, phosphorus levels

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.