Crysvita

(burosumab-twza)

Provider Order Form *rev. 2/9/2026*

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, Serum Phosphorus, Recent Labs

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:_____ Patient Name:_____ DOB:_____

ICD-10 code: ☐ E83.31._____ ☐Other:_____

Description:_____

☐NKDA Allergies:_____Weight (lb/kg)_____

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

PROVIDER INFORMATION

Referral Coordinator Name:_____ Referral Coordinator Email:_____

Ordering Provider:_____ Provider NPI:_____

Referring Practice Name:_____ Phone:_____ Fax:_____

Practice Address:_____ City:_____ State:_____Zip:_____

NURSING

☒ Most recent Phosphorus results (list and attach clinicals)

_____

☒ Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI

☒ Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every_____

☐ CMP ☐ at each dose ☐ every_____

☐ CRP ☐ at each dose ☐ every_____

☐ Other:_____

☐ Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Not usually indicated for this medication.

☐ acetaminophen (Tylenol) ☐500 mg/ ☐650 mg/ ☐1000 mg PO

☐ cetirizine (Zyrtec) 10 mg PO

☐ loratadine (Claritin) 10 mg PO

☐ diphenhydramine (Benadryl) ☐25 mg/ ☐50 mg ☐PO/☐IV

☐ methylprednisolone (Solu-Medrol) ☐ 40 mg/ ☐ 125 mg IV

☐ hydrocortisone (Solu-Cortef) 100 mg IV

☐ Other:_____

Dose:_____ Route:_____

Frequency:_____

THERAPY ADMINISTRATION

☒ **Crysvita** subcutaneous injection

Dose/Frequency:

☐ Pediatric Patients (less than 18 years of age)
Dose: 0.8 mg/kg every 2 weeks
(rounded to the nearest 10 mg; max dose 90 mg)

☐ Adult patients (18 years and older)
Dose: 1 mg/kg every 4 weeks
(rounded to the nearest 10 mg; max dose 90 mg)

☐ **Route:** Subcutaneous

☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ Other:_____
(If not indicated, order will expire one year from date signed)

To ensure a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS

☐ Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

_____ _____ _____

Provider Name (Print) Provider Signature Date