SPECIALTY INFUSION CENTER
An Access Infusion Care Company

# BUROSUMAB-TWZA ORDERS (Crysvita)

CENTERS AT SIC
An Access Infusion Care Managed Company

| REFERRAL CHECKLIST |
| --- |
| Please ensure the following information is included with your referral: |
| ☐ Patient Demographics and Contact Information |
| ☐ Patient Insurance Information |
| ☐ Completed H&P and Progress Notes Including Medications and Allergies |
| ☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis |
| ☐ Serum 25-hydroxyvitamin D/Calcium level/Parathyroid levels |
| ☐ Completed and Signed Referral |
| Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient.<br>Thank you! |

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Print, complete, and fax completed form to (855) 857-3834

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| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: | Prescriber Name: |
| Address: | NPI: |
| City, State, Zip: | Address: |
| Cell: Email: | City, State, Zip: |
| Height: Weight: kg Last 4 of SSN: DOB: | Phone: Fax: |
| Allergies: | Contact Person: |

**REFERRAL STATUS** ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last injection:

**DIAGNOSIS**

☐ Dx Code/description:

**REQUIRED DOCUMENTATION** ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

Prior Therapies:

| | |
|---|---|
| ☐ Confirm patient has stopped phosphorus meds and Vit D | ☐ Confirm fasting serum phosphorus concentration < reference range for age prior to initiation of treatment |

**PRESCRIBING INFORMATION**

**LAB ORDERS**

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ Other:

**MEDICATION**

| Medication | Strength | Dose/Directions | | Quantity |
|---|---|---|---|---|
| ☒ **Burosumab-twza (Crysvita)** | 10mg/ mL OR 20mg/mL OR 30mg/mL | **XLH Dosing** | | ☒ # sufficient for weight-based dose Refills: |
| | | Pediatric(>6 months)<10kg | ☐ 1mg/kg every 2 weeks(rounded to nearest 1mg) | |
| | | Pediatric(>6 months)>/=10kg | ☐ 0.8mg/kg every 2 weeks(round to nearest 10mg-Max 90mg) | |
| | | Adult | ☐ 1mg/kg every 4 weeks(round to nearest 10mg-Max 90mg) | |
| | | **TIO Dosing** | | |
| | | Pediatric (>2 years) | ☐ 0.4mg/kg every 2 weeks(round to nearest 10mg) | |
| | | Adult | ☐ 0.5mg/kg every 4 weeks(round to nearest 10mg) | |
| | | Pediatric or Adult | ☐ mg/kg every 2 weeks(round to nearest 10mg-Max180mg) | |
| | | **Other Dosing** | ☐ mg every weeks | |
| | | Inject subcutaneously, max volume per site=1.5ml. If multiple injections are required, administer at different injection sites. | | |

***If not specified, order will be valid for 1 year from the date of signature.***

**NURSING INSTRUCTIONS/EMERGENCY MEDICATION**

| | |
|---|---|
| RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines<br>Post-Infusion:Use 50ml0.9%NS to flush residual priming volume | PIV:Flush 3-10mL0.9%NS before/after<br>PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final |

Administer the following medications as needed for infusion-related reactions per company protocol:
**Adults>40kg:**Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
**Pediatrics/Adults<40kg:**Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
**Oxygen(AIC/AIS only):**1-6L/min via NC/face mask; titrate to maintain $SpO_2$ 95-100%.

**Prescriber Signature X:** _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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