

Burosumab-twza (Crysvita)



Provider Order Form rev. 9/22/2021

PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)
- Most recent Phosphorus results _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- Burosumab-twza** (Crysvita) subcutaneous injection
 - Pediatric patients less than 10kg
 - Dose: 1mg/kg (Rounded to the nearest 1mg)
 - Other _____mg/kg
 - Frequency: every two weeks
 - Pediatric patients 10kg and greater
 - Dose: 0.8mg/kg (Rounded to the nearest 10mg. Max dose 90mg.)
 - Other _____mg/kg
 - Frequency: every two weeks
 - Adult patients (18 years and older)
 - Dose: 1mg/kg (Rounded to the nearest 10mg. Max dose of 90mg.)
 - Other _____mg/kg
 - Frequency: Every four weeks
- Route: subcutaneous (maximum volume per injection is 1.5ml. If multiple injections are required, administer at different injection sites)
- Patient is required to stay for 30-minute observation post infusion/injection
 - Patient is NOT required to stay for observation time
 - Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Provider Name (Print) _____ Provider Signature _____ Date _____

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> TAMPA: 844-946-0849 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
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