INTRAMED Plus
infusion services

CRYSVITA®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Familial Hypophosphatemia ICD-10 Code: E83.31
_____ Other: _____ ICD-10 Code:_____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Recent lab results including baseline serum phosphorous and serum creatinine
- Medication List
  - Patients should discontinue oral phosphate and Vit D analogues by: _____

Patient
Weight: _____ lbs.
Height:_____ in.

Infusion Center – Lab Orders: (Check order for Infusion Center to manage):

❑ Serum Phosphorous level at baseline and then every 4 weeks for the duration of therapy

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CRYSVITA® (burosumab-twza) J Code: J0584

4. Drug Order:

*****NOTE: Maximum dose 90 mg per dose *****

❑ **Pediatric Familial Hypophosphatemia** _____# Refills (Recommend 25 Refills)
- ❑ Peds <10 Kg: Administer 1 mg/kg rounded to the nearest 1 mg (_____ mg) subcutaneously every 2 weeks
- ❑ Peds >10 Kg: Administer 0.8 mg/kg rounded to the nearest 10 mg (_____ mg) subcutaneously every 2 weeks

❑ **Adult Familial Hypophosphatemia** _____# Refills (Recommend 11 Refills)
Administer 1 mg/kg rounded to the nearest 10 mg (_____ mg) subcutaneously every 4 weeks

❑ **Other** _____# Refills
Administer _____ mg/kg rounded to the nearest 10 mg (_____ mg) subcutaneously every _____ weeks

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**