BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

BUROSUMAB-TWZA ORDERS (Crysvita)

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. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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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 Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after 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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