CRYSVITA (BUROSUMAB)
INFUSION ORDERS

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ X-linked hypophosphatemia (XLH) (ICD-10 Code: E83.31)

☐Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Adult XLH ☐ 1mg/kg subcutaneously rounded to nearest 10mg, every 4 weeks (MAX Dose 90mg)

Pediatric XLH ☐ 0.8 mg/kg subcutaneously rounded to nearest 10mg, every 2 weeks (MAX Dose 90mg)

Other dosage: _____, frequency _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

COMPREHENSIVE SUPPORT FOR CRYSVITA (BUROSUMAB) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Does the patient have a diagnosis of XLH confirmed by genetic testing or elevated fibroblast growth factor (FGF23) >30 pg/mL ☐ Yes ☐ No

☐ Does the patient have a documented inadequate response, contraindication, significant intolerance, or is not a candidate for oral phosphate therapy, calcitriol therapy, or both? ☐ Yes ☐ No If yes, which drug(s)? _____

☐ Is the patient experiencing clinical signs and symptoms of the disease (e.g., limited mobility, musculoskeletal pain, bone fractures) ☐ Yes ☐ No

☐ Does the patient have raphic evidence of rickets or other bone disease attributed to XLH? ☐ Yes ☐ No

☐ Include labs and/or test results to support diagnosis

☐ Low serum phosphorus (attach)

☐ Genetic test results or fibroblast growth factor (attach)

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **Serum phosphorus (attached)**

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance