Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

CRYSVITA (burosumab)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ Baseline fasting serum phosphorus attached

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ X-linked hypophosphatemia (XLH) (ICD-10: _____)

Pt. Weight _____ kg Allergies:_____

CRYSVITA ORDERS

Adult XLH ☐ 1 mg/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 Does 90mg)

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	