ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

❑ Allenmore Infusion Center
❑ Auburn Infusion Center
❑ Gig Harbor Infusion Services
❑ Puyallup Infusion Center
❑ DHEC Infusion Center
❑ North Spokane Infusion Center
❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Burosumab-twza (Crysvita):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Hypophosphatemia, X-linked

ICD -10 Code:
❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline Labs Required:

- Fasting serum phosphorus level prior to first dose: Date of test: _____ Phosphorus level _____
  ** fasting serum phosphorus concentration should be below the reference range (2.5-4.5 mg/dL) prior to initiation of treatment

Maintenance labs required:

- Fasting serum phosphorus level 2 weeks post-dose then every month for the first 3 months of treatment.
  Verify level prior to giving

Treatment Regimens:

Burosumab-twza (Crysvita) given SUBQ

❑ 1 mg/kg = _____ mg every 4 weeks. Maximum dose is 90 mg. Round to the nearest 10 mg.

Dose Adjustments: Serum phosphorus above normal range, hold next dose; reassess fasting serum every 4 weeks; once serum phosphorus falls below the normal range,may reinitiate burosumab-twza at a reduced dose (approx. half the initial starting dose). Recheck fasting serum phosphorus every 2 weeks after dose adjustment; based on results, determine if additional dosing adjustment is necessray.

☑ **Vital signs:** Check vital signs prior to and at completion of dose.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
HYPOPHOSPHATEMIA

MultiCare