BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/____

Height _____ Weight _____

Infusion Location: (state and site) _____

Crysvita® (burosumab-twza) Treatment Orders

☐ Familial hypophosphatemia	☐ Other disorders of phosphorus metabolism
☐ Tumor Induced Osteomalacia	☐ X-linked hypophosphatemia

Serum phosphorus at initiation of therapy: _____ mg/dL Date: _____

☐ Patient has been provided with lab order and instructions to assess fasting serum phosphorus on a monthly basis, measured 2 weeks post-dose, for the first 3 months of treatment, and thereafter as appropriate. To prevent delays in patient care, please indicate on lab order "CC results to Infusion Services: fax (603-237-1250)"

Nursing Orders: Hold treatment and notify provider if:

- Serum phosphorus within or above normal range at *initiation of therapy*
- Serum phosphorus above normal range for patients *already on therapy*
- Pt reports taking oral phosphate and/or active vitamin D analogs (e.g. calcitriol, paricalcitol, doxercalciferol, calcifediol) within 1 week prior to initiation of treatment
- Ensure that provider is monitoring 25-hydroxy-vitamin D levels
- CrCl<30

Dosing: Patient weight: _____ kg

Administer Crysvita _____ mg (round to nearest 10 mg).

Dosing information for Adults:

XLH: 10mg-90mg max (usually 1mg/kg) max of 90mg every 4 weeks

TIO: 0.5mg/kg to 2mg/kg max of 180mg every 2 weeks

Administer subcutaneously in the upper arm/abdomen/upper thigh. Maximum volume per site is 1.5 ml

Dose adjustments should not occur more frequently than every 4 weeks

☐ Every 2 weeks
☐ Every 4 weeks

Observation Period:

Following *initial* Crysvita treatment, observe patient for 15 minutes for hypersensitivity. Patients who have previously tolerated Crysvita do not require observation period

If hypersensitivity reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Additional Orders: _____

Provider Name (print) _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 4/13/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.