

Patient Information

Demographics Attached

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of prescription/medical card(s) (front and back).

Medical Information

Diagnosis: X-linked hypophosphatemia (XLH) **ICD-10 Code:** _____

Patient Weight: _____ lbs. **Allergies:** _____

Baseline fasting serum phosphorus attached

Clinical/progress notes, labs and tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

Crysvita Orders

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

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

Additional Orders/Comments:

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ **Physician Name:** _____ **Date:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX
Phoenix, AZ Other: _____

HY-VEEHEALTHINFUSION.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.