Hy-Vee health INFUSION CARE

CRYSVITA (BUROSUMAB) Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

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: _____

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