Crysvita

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order. Most recent office visit note, Patient Demographic & Insurance Information, Medication List, Serum Phosphorus

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ E83.31 Familial hypophosphatemia
☐ M83.8 Other adult osteomalacia

Other Dx/ICD10:

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

CRYSVITA DOSAGE

Date of Last Treatment, If Continuation: _____

☐ **Pediatric Dosage: 0.8 mg/kg Q 2 weeks (rounded to the nearest 10mg)**

☐ **Adult Dosage: 1 mg/kg Q 4 weeks (rounded to the nearest 10mg)**

Route: ☑ SQ

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

LAB ORDERS

☐ List:

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.