



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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Crysvita (burosumab-twza) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

E83.31 Familial Hypophosphatemia

Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

Acetaminophen:

1000mg PO 500mg PO

Diphenhydramine:

25mg PO 50mg PO 25mg IV 50mg IV

Hydrocortisone: 100mg IVP

Other Pre-medication: _____

No Pre-medications indicated

5. Drug Order:

Crysvita (burosumab-twza) *Ok to substitute with generic/biosimilar*

1mg/kg (rounded to the nearest 10mg) every 4 weeks (maximum dose is 90mg)

Other: _____

Special Instructions: _____

New to Therapy

Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

Serum phosphorus levels monthly (2 weeks following each dose for the first 3 months of therapy)

Other: _____

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Baseline Lab/Testing completed:

Serum Phosphorus level, date: _____ Other: _____

8. Patient Assistance & REMS Program Enrollment

Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)

No, patient has not been enrolled in any programs.

7. Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)