Allergy, Asthma & Immunology Center, P.C.
Infusion Services

www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

CRYSVITA® (BUROSUMAB-TWZA) ORDER FORM

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

CRYSVITA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ______________________________

____ Dosing: 1 mg/kg body weight administered every four weeks
(Rounded to the nearest 10 mg up to a maximum dose of 90 mg)

Physician Signature* ______________________________

Date*(Order is Valid for One Year) ____________________
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ X-linked hypophosphatemia

_____ Other__________________________

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Elevated Serum Fibroblast 23 > 30pg/ml (if available)

_____ Serum Phosphorus

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ______________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

-------Oklahoma-------

___ Tulsa

REVISION DATE- 5/2020