



**CRYSVITA (BUROSUMAB)
INFUSION ORDERS**

P: 877.365.5566 | F: 855.889.2946

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis: X-linked hypophosphatemia (XLH) (ICD-10 Code: E83.31)

Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

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

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

Other dosage: _____, frequency _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: Paragon Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

Opt out of Paragon selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

View our locations here:



PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address 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.

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - Does the patient have a diagnosis of XLH confirmed by genetic testing or elevated fibroblast growth factor (FGF23) >30 pg/mL Yes No
 - Does the patient have a documented inadequate response, contraindication, significant intolerance, or is not a candidate for oral phosphate therapy, calcitriol therapy, or both? Yes No If yes, which drug(s)? _____
 - Is the patient experiencing clinical signs and symptoms of the disease (e.g., limited mobility, musculoskeletal pain, bone fractures) Yes No
 - Does the patient have raphic evidence of rickets or other bone disease attributed to XLH? Yes No
- Include labs and/or test results to support diagnosis
 - Low serum phosphorus (attach)
 - Genetic test results or fibroblast growth factor (attach)
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- Serum phosphorus (attached)**

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance