PARAGON HEALTHCARE

A Carelon Company

CRYSVITA (BUROSUMAB) THERAPY INJECTION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Crysvita (burosumab)	☐ Adult XLH 1mg/kg subcutaneously rounded to nearest 10mg, every 4 weeks ☐ Pediatric XLH 0.8 mg/kg subcutaneously rounded to nearest 10mg, every 2 weeks ☐ Other dose: _____	☐ x 1 year ☐ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by ☐ Paragon Healthcare ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR CRYSVITA (BUROSUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROSSING & 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**