



**PATIENT INFORMATION**

*Demographics attached*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK**

**MEDICAL INFORMATION**

Diagnosis:  X-linked hypophosphatemia (XLH) ICD-10 Code: \_\_\_\_\_

Patient Weight \_\_\_\_\_ lbs. Allergies: \_\_\_\_\_

Baseline fasting serum phosphorus attached

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

**Labs:** Required labs to be drawn by:  Infusion Clinic  Referring Physician

**Lab Orders:** \_\_\_\_\_

**CRYSVITA ORDERS**

**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)

**Additional Orders/Comments:**

**PHYSICIAN 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.*

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

**INFUSION CENTER LOCATIONS**

**Phone: 877-365-5566**  
**Fax: 855-889-2946**

**Texas**

Arlington  Austin  Dallas  Houston  North Hills  
 Plano  Round Rock  San Antonio  Stone Oak

**Tennessee**

Knoxville

**Georgia**

Atlanta

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