

# REZZAYO® (rezafungin)

## Referral Form



Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:	Lic.#:	DEA #:	
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:	Fax:	
Supervisory Physician (if applicable):			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical)		Most recent liver function panel	
Recent office visit notes, history & physical, lab & pertinent procedure results		Culture & sensitivity results	
Current medication list & list of prior medications tried and failed (with dates)		Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
Line access documentation/verification if applicable			
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
<b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
<b>Lab Orders:</b> _____			
<b>Lab Date &amp; Frequency:</b> _____			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? Yes No If No, when was last dose given? _____ When is patient due for next dose? _____			
<b>Anaphylaxis Kit:</b>	Epinephrine 0.3mg IM as needed	Solu-Cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other
REZZAYO	Induction: 400mg IV in 250ml NS/D5W over 1 hour via gravity ---OR--- pump		NONE
	Maintenance: 200mg IV in 250ml NS/D5W over 1 hour via gravity ---OR--- pump once weekly beginning on day 8 for up to 4 doses		_____
OTHER DOSING REGIMEN			_____

**By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.**

\_\_\_\_\_  
**Prescriber's Signature                      Print Name                      Date                      Prescriber's Signature                      Print Name                      Date**

