REZZAYO®(rezafungin)
Referral Form

Fax Completed Form To: 877-418-4495 **Phone: 877-418-4114**

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

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

Flush Orders: *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

Lab Orders: ____________________

Lab Date & Frequency: ____________________

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?__________		
Anaphylaxis Kit:	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

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