

# 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**



ACHC ACCREDITED

