# 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)
- Recent office visit notes, history & physical, lab & pertinent procedure results
- Current medication list & list of prior medications tried and failed (with dates)
- Line access documentation/verification if applicable
- Most recent liver function panel
- Culture & sensitivity results
- Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

### 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:** (Check all that apply) | Epinephrine 0.3mg IM as needed; Solu-Cortef 250mg-500mg IV infusion as needed; Solu-Medrol 60mg - 125mg IV infusion as needed; 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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ACHC ACCREDITED