

# 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:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical)	<input type="checkbox"/> Most recent liver function panel
<input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results	<input type="checkbox"/> Culture & sensitivity results
<input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)	<input type="checkbox"/> Letter of medical necessity if drug dosing or indication is outside of FDA guidelines
<input type="checkbox"/> 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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
<b>Anaphylaxis Kit:</b> <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-Cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other		
<input type="checkbox"/> REZZAYO	<input type="checkbox"/> Induction: 400mg IV in 250ml NS/D5W over 1 hour via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump <input type="checkbox"/> Maintenance: 200mg IV in 250ml NS/D5W over 1 hour via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly beginning on day 8 for up to 4 doses	NONE
<input type="checkbox"/> 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 \_\_\_\_\_  
 Dispense as Written \_\_\_\_\_

Print Name

Date

Prescriber's Signature \_\_\_\_\_  
 Substitution Permitted \_\_\_\_\_

Print Name

Date

