REZZAYO®(rezafungin)
Referral Form

amerita specialty infusion services

NEXTRON Infusion Services an amerita company

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)
- ☐ 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: ☐ 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**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

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URAC ACCREDITED Specialty Pharmacy 06/01/2022 ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy