

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
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 ☐ 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	NONE
☐ OTHER DOSING REGIMEN		

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date