Rezzayo Order Form
(rezafungin)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

ICD 10 Code: _____

Description: _____

***REQUIRED*: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

***LAB RESULTS*: CMP or AST/ALT within last 90 days. Include culture report.**

PRESCRIPTION

Rezzayo (rezafungin)

Initial Dose:

IV: Infuse 400 mg in 250 mL of 0.9% Sodium Chloride over 60 minutes

Lab Orders+

+ Medix Infusion will draw required CBC/AST/ALT if not supplied by Referring Provider.

Maintenance:

IV: Infuse 200 mg in 250 mL of 0.9% Sodium Chloride over 60 minutes weekly for _____ weeks

Maintenance dosing to start 1 week following initial dose

Post Treatment Observations: The patient is observed for 30 minutes following the first and second infusion.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____