

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)****Lab Orders+****Loading Dose**

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

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

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

Is the patient on any other disease modifying therapy? **Yes** **No**
If yes, please note therapy and last dose: _____

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

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

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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