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: _____

Diagnosis

ICD 10 Code (PROVIDE COMPLETE CODE)

ICD 10 Code: _____

Description: _____

Medication Order

REZZAYO (rezafungin)

Loading Dose

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

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

Lab Orders+

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

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

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: _____

Required Clinical Documentation

REQUIRED: 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.

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

_____

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Patient Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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