immersiv HEALTH

REZZAYO® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ Culture report

MEDICATION ORDER

☐ **LOADING:** Rezzayo® (rezafungin) 400mg IV in 250ml NS over 60 minutes

☐ **MAINTENANCE:** Rezzayo® (rezafungin) 200mg IV in 250ml NS over 60 minutes once weekly for 3 doses, one week following loading dose

☐ **OTHER:** _____

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN