

**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:** \_\_\_\_\_

**PRE-MEDICATIONS**

- PO**
- Acetaminophen: 650 mg
- Cetirizine: 10 mg
- Diphenhydramine: 25 mg
- IV**
- Methylprednisolone: 125 mg
- Diphenhydramine: 25 mg
- OTHER:** \_\_\_\_\_  PO  IV

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

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED      DISPENSE AS WRITTEN