INTRAMED Plus
infusion services

REZZAYO™

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: ___ Candidemia / invasive candidiasis ICD-10 Code: B37.__

___ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

Patient Weight: _____ lbs Height: _____ inches

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical notes, labs, and any tests supporting primary diagnosis
- Medication List

Infusion Center — Lab Orders (Check Order for Infusion Center to Manage):

❑ _____

REZZAYO™ (rezafungin) J Code: J0349

4. Drug Order:

❑ **Loading Dose:** 400 mg

Administer 400 mg (250 mL) IV over one hour on **Day 1**

Authorized Doses: 1 (one)

❑ **Maintenance Regimen:** 200 mg — Starting on **Day 8**

Administer 200 mg (250 mL) IV over one hour once weekly for up to 4 doses*

Authorized Doses: _____(max of 4 (four))

Safety of Rezzayo™ has not been established beyond 4 weekly doses

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**