



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE, if applicable)

- | | |
|--|--|
| <input type="checkbox"/> B37.1 Pulmonary Candidiasis | <input type="checkbox"/> B37.81 Candidal esophagitis |
| <input type="checkbox"/> B374.9 Other urogenital candidiasis | <input type="checkbox"/> B37.82 Candidal enteritis |
| <input type="checkbox"/> B37.7 Candidal sepsis | <input type="checkbox"/> B37.89 Other sites of candidiasis |
| <input type="checkbox"/> B37.8 Candidiasis of other sites | <input type="checkbox"/> Other: _____ |

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy
LAB RESULTS: Include negative TB and negative Hepatitis B (if positive, provide documented medical treatment or clearance) prior to initiating therapy

PRESCRIPTION

Pre-Medications

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO | <input type="checkbox"/> Acetaminophen: _____ mg PO |
| <input type="checkbox"/> Cetirizine 10 mg PO | <input type="checkbox"/> Famotidine: _____ mg IV |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO | <input type="checkbox"/> Methylprednisolone: _____ mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV | <input type="checkbox"/> Ondansetron 4 mg IV |
| <input type="checkbox"/> Other: _____ | |

Lab Orders

- CBC w/diff: every _____ weeks month
 CMP: every _____ weeks month
 Other: _____ weeks month

Rezzayo (rezafungin)

Loading Dose (SELECT ONE)

- IV: infuse 400 mg x 1 dose

Maintenance Dose (SELECT ONE)

- IV: Infuse 200 mg weekly x _____ 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: _____

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____