

## Dalvance (dalbavancin) Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### 1. Required Documentation - Please submit the following with signed order form:

- Insurance information    • Demographics    • Clinical/progress notes    • History & physical
- Relevant labs/tests: serum creatinine, supporting documentation of diagnosis (ex. cultures/susceptibilities)
- List tried and failed therapies, including duration of treatment (required to obtain authorization):

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

### 2. Patient information:

Male    Female    Height: \_\_\_\_\_ in    cm    Weight: \_\_\_\_\_ lbs    kg  
Allergies: \_\_\_\_\_ NKDA    Line type:    PIV    PICC    Port    No. of lumens \_\_\_\_\_

### 3. Diagnosis and ICD 10 Code

Cellulitis of unspecified part of limb (L03.119)    Cellulitis of left upper limb (L03.114)  
Cellulitis of right upper limb (L03.113)    Cellulitis of left lower limb (L03.116)  
Cellulitis of right lower limb (L03.115)    Other: \_\_\_\_\_ ICD10: \_\_\_\_\_

### 4. Prescription Information: Dalvance 500 mg vials

Normal Renal Function CrCl ≥30 mL/min (or on regular hemodialysis)		Renal Dosing CrCl <30 mL/min (& not on regular hemodialysis)	
Dalvance (select one): 1500 mg IV once 1000 mg followed one week later by 500 mg IV 1500 mg followed 7-14 days later by 1500 mg IV		Dalvance (select one): 1125 mg IV once 750 mg followed one week later by 375 mg IV	
Other: Dalvance _____ mg IV every _____ weeks for a total of _____ doses			
Directions	Prepare product for IV infusion per manufacturer guidelines using compatible IV solution Infuse IV over 30 minutes as tolerated		
Quantity & Refills	Dispense quantity sufficient to complete prescribed regimen. No refills unless otherwise stated. Dispense all medical supplies necessary for infusion Other: _____		

### 5. Additional Orders:

RN to start peripheral IV or use existing CVC and administer catheter flushing per Coastal Infusion Services Policy & Procedure\*

\*Note: If same IV line is used to administer drugs in addition to Dalvance, flush with dextrose 5% per manufacturer

### 6. Adverse Reaction Orders: Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and solumedrol 125mg IV. Additional orders: \_\_\_\_\_

### 7. Prescriber Information

Prescriber Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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