

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 PromptCare 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 NS 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.

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.