

**DALBAVANCIN (DALVANCE®) PRESCRIBER ORDER FORM**

Patient Name:

Date of Birth:

Address:

Phone:

Height:

☐ inches ☐ cm

Weight:

☐ lbs ☐ kg**Clinical Information**

Primary Diagnosis Description:

ICD-10 Code:

Allergies:

**Dalbavancin (Dalvance®) Prescription****Choose One:**

- Single Dose Regimen: ☐ Infuse 1500 mg IV over 30 min for one dose only (CrCL  $\geq$  30 mL/min).  
☐ Infuse 1125 mg IV over 30 min for one dose only (CrCL < 30 mL/min).
- Two Dose Regimen: ☐ Infuse 1000 mg IV over 30 min once followed by 500 mg IV over 30 min one week later (CrCL  $\geq$  30 mL/min).  
☐ Infuse 750 mg IV over 30 min once followed by 375 mg IV over 30 min one week later (CrCL < 30 mL/min).
- ☐ Other: \_\_\_\_\_

***Dalbavancin (Dalvance®) is not compatible with saline-based infusion solutions. Only D5W should be used for dilution and flushing.***

**Ancillary Orders****Anaphylaxis Kit**If this is a 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?☐ Yes☐ No**IV Flush Orders**

- ☐ Peripheral: Dextrose 5% in water 3 to 5 mL pre-/post-use. Discontinue peripheral line after completion of infusion.
- ☐ Other: \_\_\_\_\_

**Lab Orders**

- ☐ No labs ordered at this time.
- ☐ Other: \_\_\_\_\_

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Prescriber Information**

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

**Fax completed form, insurance information, and clinical documentation to:**

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