

DALBAVANCIN (DALVANCE®) PRESCRIBER ORDER FORM				
Patient Name:		Date of Birth:		Gender:
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Allergies:				
Dalbavancin (Dalvance®) Prescription				
<p><u>Choose One:</u></p> <p>Single Dose Regimen: <input type="checkbox"/> Infuse 1500 mg IV over 30 min for one dose only (CrCL ≥ 30 mL/min). <input type="checkbox"/> Infuse 1125 mg IV over 30 min for one dose only (CrCL < 30 mL/min).</p> <p>Two Dose Regimen: <input type="checkbox"/> Infuse 1000 mg IV over 30 min once followed by 500 mg IV over 30 min one week later (CrCL ≥ 30 mL/min). <input type="checkbox"/> Infuse 750 mg IV over 30 min once followed by 375 mg IV over 30 min one week later (CrCL < 30 mL/min).</p> <p><input type="checkbox"/> Other: _____</p> <p style="color: red;"><i>Dalbavancin (Dalvance®) is not compatible with saline-based infusion solutions. Only D5W should be used for dilution and flushing.</i></p>				
Ancillary Orders				
<p>Anaphylaxis Kit</p> <p>If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?</p> <p style="padding-left: 40px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>IV Flush Orders</p> <p><input type="checkbox"/> <u>Peripheral:</u> Dextrose 5% in water 3 to 5 mL pre-/post-use. Discontinue peripheral line after completion of infusion.</p> <p><input type="checkbox"/> <u>Other:</u> _____</p>				
<p>Lab Orders</p> <p><input type="checkbox"/> No labs ordered at this time.</p> <p><input type="checkbox"/> Other: _____</p>				
<p>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.</p> <p>If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.</p>				
<p><i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i></p>				
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:				
<p><small>CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted 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 laws. 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 dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</small></p>				