



option care health®

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to \_\_\_\_\_.

Sincerely,  
Option Care Health

# DALBAVANCIN (DALVANCE®) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Gender:

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 ≥ 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 ≥ 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.

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.

*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:

**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.