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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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:**	

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

Not valid for use for patients residing in Arizona, New York, and Wisconsin