DALVANCE® Infusion Form

Fax Referral To:
877-438-9380

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ____________________ Next Infusion Date: ____________________

Patient Information

Patient Name: ____________________ DOB: ____________ Sex: M F Height: ______ Weight: ____________

Phone Number: ____________________ Email Address: ____________________

Allergies: ____________________ Is the patient Diabetic: Y N ICD-10 Code: ____________

Emergency Contact: ____________________ Phone Number: ____________________

Primary Diagnosis:

____

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Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including BUN & Creatinine

Physician Information

Prescribing Physician: ____________________ Practice Name: ____________________
Practice Phone: ____________________ Practice Fax: ____________________
Email: ____________________ Office Contact: ____________________
Co-managing Physician: ____________________ Phone/Email: ____________________

Medication Order

Medication: **DALVANCE® (dalbavancin)**

Administer 1,500 mg Dalvance IV as a one-time dose over 30 minutes

Administer 1,000 mg Dalvance IV over 30 minutes and then 500 mg Dalvance IV over 30 minutes one week later

Dose adjustment for CrCl < 30 ml/hr (Select one)

Administer 1,125mg Dalvance IV as a one-time dose over 30 minutes OR

Administer 750mg Dalvance IV over 30 minutes and then 375mg Davlance IV over 30 minutes one week later

Other: ____

Pre-Medication Orders: No Pre-Meds recommended

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

____________________ Physician's NPI#

____________________ Physician's Address

____________________ Prescriber's Signature

____________________ Date

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