EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Dalvance Order Form
(dalbavancin)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

ICD 10 Code: _____

Description: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **CMP or BMP within last 90 days.**

PRESCRIPTION

DALVANCE (dalbavancin)
Infuse dose in D5W for a total volume of 250-300 mL as a single dose over 30 minutes

DO NOT USE Normal Saline for dilution or flushing of IV line as it is incompatible with Dalvance

Single Dose Regimen
Estimated Creatinine Clearance: **(SELECT ONE)**
- ≥ 30 mL/min or on regular hemodialysis:
  - ☐ **IV:** Infuse 1500 mg
- < 30 mL/min and not on regular hemodialysis:
  - ☐ **IV:** Infuse 1125 mg

Two Dose Regimen
Estimated Creatinine Clearance: **(SELECT ONE)**
- ≥ 30 mL/min or on regular hemodialysis:
  - ☐ **IV:** Infuse 1000 mg, then one week later infuse 500 mg
- < 30 mL/min and not on regular hemodialysis:
  - ☐ **IV:** Infuse 750 mg, then one week later infuse 375 mg

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Lab Orders+

Do you have CMP Results within 90 days?

☐ **Yes** ☐ **No**

+Medix Infusion will draw required CBC/BMP if not supplied by Referring Provider

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____