

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M / F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs / kg  
Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Patient Preferred Location: \_\_\_\_\_

&lt;ICD 10 CODE REQUIRED&gt;

## 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.**

## 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 Regiment:**Estimated Creatinine Clearance: **(SELECT ONE)**

≥ 30 mL/min or on regular hemodialysis:

 IV: Infuse 1500 mg

&lt; 30 mL/min and not on regular hemodialysis:

 IV: Infuse 1125 mg**Two Dose Regiment:**Estimated Creatinine Clearance: **(SELECT ONE)**

≥ 30 mL/min or on regular hemodialysis:

 IV: Infuse 1000 mg, then one week later infuse 500 mg

&lt; 30 mL/min and not on regular hemodialysis:

 IV: Infuse 750 mg, then one week later infuse 375 mg

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

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

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ *Signature:* \_\_\_\_\_

Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Supervising Physician: \_\_\_\_\_ (If Applicable)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_