

**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: Include culture report.**

**PRESCRIPTION**

**Kimyrsa (oritavancin)**

Start and follow each infusion with 10 mL of 0.9% Sodium Chloride flush.

Dose:

**IV:** Infuse 1200 mg in 0.9% Sodium Chloride for a total volume of 250 mL as a single dose over 1 hour

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: \_\_\_\_\_