

**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.**  
**LAB RESULTS: Include culture report.**

**PRESCRIPTION**
**Orbactiv (oritavancin)**

Start and follow each infusion with a 10 mL D5W flush. **DO NOT USE Normal Saline for dilution or flushing of IV line as it is incompatible with Orbactiv.**

Dose:  
**IV: Infuse 1200 mg in D5W for a total volume of 1000 mL as a single dose over 3 hours**

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 infusion.

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

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ *Signature:* \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Supervising Physician: \_\_\_\_\_ (If Applicable)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_