

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 (PROVIDE COMPLETE 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**Loading Dose****IV:** Infuse 1200 mg in D5W for a total volume of 1000 mL as a single dose over 3 hours**Post Treatment Observations:** The patient is observed for 30 minutes following the 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: _____