DALBAVANCIN (DALVANCE®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Allergies:

Dalbavancin (Dalvance®) Prescription

Choose One:

Single Dose Regimen:
- ☐ Infuse 1500 mg IV over 30 min for one dose only (CrCL ≥ 30 mL/min).
- ☐ Infuse 1125 mg IV over 30 min for one dose only (CrCL < 30 mL/min).

Two Dose Regimen:
- ☐ Infuse 1000 mg IV over 30 min once followed by 500 mg IV over 30 min one week later (CrCL ≥ 30 mL/min).
- ☐ Infuse 750 mg IV over 30 min once followed by 375 mg IV over 30 min one week later (CrCL < 30 mL/min).

☐ Other: _____

Dalbavancin (Dalvance®) is not compatible with saline-based infusion solutions. Only D5W should be used for dilution and flushing.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes – please complete Anaphylaxis Physician Order (FR-PC-036) ☐ No

IV Flush Orders

☐ Peripheral: D5W 3 to 5 mL pre-/post-use. Discontinue peripheral line after completion of infusion.

☐ Other: _____

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

