

DALBAVANCIN (DALVANCE®) PRESCRIBER ORDER FORM

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



Patient Name:	Date of Birth:		
Address:			
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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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:

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