MRN:_____
DOB: _____

Standard Plan of Treatment for Kimyrsa™ (oritavancin)

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. **Patient Name**: _____Height (in.):_____ Weight: _____
2. **Allergies**: _____
3. **Diagnosis:**
   ☐ ICD-10 Code: _____ Diagnosis Description: _____

4. Orders: Kimyrsa™ (oritavancin) 1200mg IV in 250ml of 0.9% sodium chloride injection or 5% dextrose in sterile water (D5W) to infuse over 1 hour x 1 single dose.

Observe patient for 30 minutes after infusion is complete.

Special Orders: _____

Lab orders with infusion: _____

_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature: _____/_____ **Date**: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

MRN:_____
DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Guidelines for Prescribing Kimyrsa™ (oritavancin)

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any lab results and/or tests to support diagnosis.**

- Kimyrsa™ is indicated for the treatment of adult patients with acute bacterial skin and skin structure infections (ABSSSI) caused by susceptible isolates of the following Gram-positive microorganisms: Staphylococcus aureus (including methicillin-susceptible and methicillin-resistant isolates), Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus dysgalactiae, Streptococcus anginosus group (includes S. anginosus, S. intermedius, and S. constellatus), and Enterococcus faecalis (vancomycin-susceptible isolates only).

☐ Other as requested: _____

_____

_____

----------WARNINGS AND PRECAUTIONS----------

• Coagulation test interference: Oritavancin has been shown to artificially prolong aPTT for up to 120 hours, and may prolong PT and INR for up to 12 hours and ACT for up to 24 hours. For patients who require aPTT monitoring within 120 hours of KIMYRSA dosing, consider a non-phospholipid dependent coagulation test such as a Factor Xa (chromogenic) assay or an alternative anticoagulant not requiring aPTT. (5.1, 7.2) • Serious hypersensitivity reactions, including anaphylaxis, have been reported with the use of oritavancin products, including KIMYRSA. Discontinue infusion if signs of acute hypersensitivity occur. Carefully monitor patients with known hypersensitivity to glycopeptides. (5.2) • Infusion Related Reactions: Infusion related reactions have been reported with the glycopeptide class of antimicrobial agents, including oritavancin products (e.g. KIMYRSA). Stopping or slowing the infusion may result in cessation of these reactions. (5.3) • Clostridioides difficile-associated diarrhea: Evaluate patients if diarrhea occurs. (5.4) • Concomitant warfarin use: Oritavancin has been shown to artificially prolong PT/INR for up to 12 hours (5.1). Patients should be monitored for bleeding if concomitantly receiving KIMYRSA and warfarin. (5.5) • Osteomyelitis: Institute appropriate alternate antibacterial therapy in patients with confirmed or suspected osteomyelitis. (5.6)

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.