Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Dalvance® (Dalbavancin) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:				
Patient Name:			Address:				
Date of Birth:			City, State, Zip:				
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐	See list ☐	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ _____ - Other:_____

☐ _____ - Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Labs and tests results including BUN, serum creatinine and LFTs within 30-60 days		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Dosage in Patients with Renal Impairment: In patients with renal impairment whose known creatinine clearance is less than 30 mL/min and who are not receiving regularly scheduled hemodialysis, dosing adjustment is suggested.

Dilution: Use ONLY 5% dextrose in sterile water (D5W) for dilution. **Do NOT use Normal Saline for dilution or flushing of IV line** as it is incompatible with DALVANCE® and may cause precipitation of the drug. Therefore, other intravenous substances, additives, or other medications mixed in normal saline should **NOT** be added to DALVANCE® vials or infused simultaneously through the same IV line or through a common intravenous port. If the same intravenous line is used for sequential infusion of additional medications, the line should be flushed before and after infusion with D5W.

MEDICATION:

☑ **Dalvance® (Dalbavancin)** in 100--250ml of D5W IV to infuse over 30 minutes

DOSE/FREQUENCY:

Creatinine Clearance	◯ Single Dose Regimen	◯ Two-dose Regimen
≥ 30 mL/min or on regular hemodialysis	**1500mg**	**1000mg on day 0 and 500mg on day 7**
< 30 mL/min and not on regular hemodialysis	**1125mg**	**750mg on day 0 and 375mg on day 7**

◯ Other:_____

SPECIAL/LAB ORDERS:

◯ _____

_____

☑ Refills:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto InfusionAccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

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**

Palmetto Infusion 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023