

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

- Other:	
- Other:	

### REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	
5	Labs and tests results including BUN, serum creatinine and LFTs within 30-60 days	THERAPY:	

**IF ORDER CHANGE:**

**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	<b>1500mg</b>	<b>1000mg on day 0 and 500mg on day 7</b>
< 30 mL/min and not on regular hemodialysis	<b>1125mg</b>	<b>750mg on day 0 and 375mg on day 7</b>

Other: \_\_\_\_\_

### SPECIAL/LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

Refills: \_\_\_\_\_

### LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion 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