

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Orbactiv® (oritavancin) 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)

<input type="text"/>	- Other:
<input type="text"/>	- 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5		THERAPY:	
6			
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Prescribing Orbactiv® in the absence of a proven or strongly suspected bacterial infection is unlikely to provide benefit to the patient and increases the risk of the development of drug resistant bacteria.

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 Orbactiv® and may cause precipitation of the drug. Therefore, other intravenous substances, additives, or other medications mixed in normal saline should **NOT** be added to Orbactiv® 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:

- Orbactiv® (oritavancin) in 1000mL of D5W IV to infuse over 3 hours
- Flush with D5W before and after infusion **NS flushes are not compatible**

DOSE/FREQUENCY:

<input type="checkbox"/>	1200mg as one time dose
<input type="checkbox"/>	Other: _____

SPECIAL/LAB ORDERS:

<input type="text"/>

Follow infusion with a 30 minute post observation.

<input checked="" type="checkbox"/>	Refills: _____
-------------------------------------	----------------

NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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:

<input type="text"/>	<input type="text"/>
Dispense as written/Brand medically necessary	Substitution permitted