Dalvance (Dalbavancin) Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
☐ Include any Culture and Sensitivity results if available

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis and ICD-10:		

☐ **Pharmacist to review medical records and labs and make drug therapy recommendations**

OR

Single Dose Regimen

☐ Dalvance 1500 mg/300 mL D5W IV

☐ Dalvance 1125 mg/225 mL D5W IV

Two Dose Regimen

☐ Dalvance 1000 mg/200 mL D5W IV, followed 1 week later by 500 mg/100 mL D5W IV

☐ Dalvance 750 mg/200 mL D5W IV, followed 1 week later by 375 mg/100 mL D5W IV

Alternative Dosing

☐ Dalvance 1000 mg/200 mL D5W IV, followed by weekly dosing of 500 mg/100 mL D5W IV for 6 weeks

☐ Dalvance 750 mg/200 mL D5W IV, followed by weekly dosing of 375 mg/100 mL D5W IV for 6 weeks

Sig: ☐ Infuse 1 dose over 1 hour via peripheral line unless otherwise specified.

☐ Other: _____

Lab Orders: ☐ None/To be drawn by Referring Physician Office ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ Other: _____

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

☐ May use Burnham's Vital Care flush and line maintenance protocol (D5W flushes only)

Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care

☐ May use Burnham's Vital Care anaphylaxis protocol

Additional Instructions: May substitute with generic if appropriate.

Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		