Dalvance (dalbavancin)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

Cellulitis

☐ L03.011-L03.019 Cellulitis of finger
☐ L03.031-L03.039 Cellulitis of toe
☐ L03.111-L03.119 Cellulitis of other parts of limb
☐ L03.211 Cellulitis of face
☐ L03.221 Cellulitis of neck
☐ L03.311-L03.319 Cellulitis of trunk
☐ L03.811-L03.818 Cellulitis of other sites
☐ L03.90 Cellulitis, unspecified

Methicillin-resistant Staphylococcus aureus

☐ A49.02 Methicillin-resistant Staphylococcus aureus infection, unspecified site
☐ B95.62 Methicillin-resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere
☐ B95.61 Staphylococcus aureus as the cause of diseases classified elsewhere

Streptococcus

☐ A40.0-A40.9 Streptococcal sepsis
☐ A49.1 Streptococcal infection, unspecified site.
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☑ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: CMP or BMP within last 90 days
☐ Other: _____

Dalvance (dalbavancin) (Select one):

Infuse dose in D5W for a total volume of 250-300 mL as a single dose over 30 minutes. DO NOT USE Normal Saline for dilution or flushing of IV line as it is incompatible with Dalvance.

Single Dose Regiment:
Estimated Creatinine Clearance: (SELECT ONE)
≥ 30 mL/min or on regular hemodialysis:
☐ **IV:** Infuse 1500 mg
< 30 mL/min and not on regular hemodialysis:
☐ **IV:** Infuse 1125 mg

Two Dose Regiment:
Estimated Creatinine Clearance: (SELECT ONE)
≥ 30 mL/min or on regular hemodialysis:
☐ **IV:** Infuse 1000 mg, then one week later infuse 500 mg
< 30 mL/min and not on regular hemodialysis:
IV: Infuse 750 mg, then one week later infuse 375 mg

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**