

# DALVANCE® Order Form



Fax completed form to: \_\_\_\_\_

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		Referral Date:	
Home Phone:		City/State/Zip:	
Secondary Contact:		Work Phone:	
Patient Diagnosis & ICD-10:		Height:      Weight:      Male      Female	
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
Office Contact:		City/State/Zip:	
Phone:		Fax:	
Supervisory Physician (if applicable):			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable		Estimated creatinine clearance Culture & sensitivity results Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed    Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> Epinephrine 0.3mg IM as needed      Solu-Cortef 250mg-500mg IV infusion as needed      Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply)      Diphenhydramine _____ mg IV infusion as needed      NS Hydration 500 ml IV infusion over 30 minutes as needed      Other			
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose?    Yes    No    If No, when was last dose given? _____    When is patient due for next dose? _____			
DALVANCE <i>(to be mixed in DSW)</i>	Adult Dosing: Estimated Creatinine Clearance 30mL/min and above or on regular hemodialysis:    1500mg single dose regimen or    1000mg followed by one week later 500mg two dose regimen IV infusion via    gravity ---OR---    pump over 30 minutes Less than 30mL/min and not on regular hemodialysis:    1125mg single dose regimen or    750mg followed by one week later 375mg two dose regimen IV infusion via    gravity ---OR---    pump over 30 minutes		_____
OTHER			_____
<i>By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</i>			

<b>Prescriber's Signature</b> <u>Dispense as Written</u>	<b>Print Name</b>	<b>Date</b>	<b>Prescriber's Signature</b> <u>Substitution Permitted</u>	<b>Print Name</b>	<b>Date</b>
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