Dalvance Enrollment Form

Date: _____
Patient Name: _____
Date of Birth: _____

TwelveStone Health Partners

Fax Referral To:
(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last injection date: _____

Next injection date: _____

If NO, please indicate desired location for first dose:

☐ Physician's office
TwelveStone Infusion Center
☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro
☐ Other: _____
Desired start date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Acute Bacterial Skin and Soft Tissue Infection	☐ L08.9 ☐ Other:_____
☐ Other	

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

☐ This signed order form ☐ History and Physical

☐ Patient Demographics and Insurance Information ☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg Height: _____ Inches/CM BSA: _____ Allergies: _____

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size _____ Gauge _____ Length _____) ☐ SubQ

Estimated Creatinine Clearance	Single Dose Regimen	Two Dose Regimen	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ 30 mL/min and above or on regular hemodialysis	☐ 1500 mg	☐ Infuse 1000 mg IV over 30 minutes, followed one week later by 500mg		☐ Liver Panel
☐ Less than 30 mL/min and not on regular hemodialysis	☐ 1125 mg	☐ Infuse 750 mg IV over 30 minutes, followed one week later by 375mg		☐ CBC w/ Differential
☐ Other		☐ Infuse____mg IV over 30 minutes; follow up dose one week later by _____ mg		☐ BMP

LAB ORDERS - To be drawn by TwelveStone

Order			Frequency	
CBC w/ Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
CBC w/o Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
CMP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
BMP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
CRP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Sed Rate	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Calcium	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Tb QuantiFERON Gold	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Hepatitis Panel	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Other:	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____

Pre-medications - *Recommended/Check here for NO pre-meds ordered _____

Oral
Acetaminophen: [ ] 325mg [ ]500mg [ ] 650mg
Cetirizine: [ ] 10mg
Diphenhydramine: [ ] 25mg [ ] 50mg
Famotidine: [ ] 20mg [ ] 40mg
Ibuprofen: [ ] 200mg
Loratidine: [ ] 10mg
Ondansetron: [ ] 4mg

IV
Dexamethasone: [ ] 4mg [ ] 8mg
Diphenhydramine: [ ] 25mg [ ] 50mg
Famotidine: [ ] 20mg [ ] 40mg
Methylprednisolone: [ ] _____ mg IV over _____ mins
Ondansetron: [ ] 4mg [ ] 8mg

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone: _____ Physician's NPI#: _____ Physician's Fax# : _____ Physician's Address: _____

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

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