

DALVANCE ORDER FORM

Date: _____

ICD-10 Code: _____

Patient Name: _____

Allergies: _____

Date of Birth: _____

Weight: _____ lbs OR _____ kg

Therapy Status

Provider Information

Please check any of the following that apply:

New Start

Continuing Therapy:

Last Dose: _____

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

Dalvance

Dalvance 1,500mg IV x one dose per protocol.

Dalvance 1,125mg IV x one dose per protocol.

Dalvance 1,000mg IV x one dose, followed by 500mg IV one week later per protocol.

Dalvance 750mg IV x one dose, followed by 375mg one week later per protocol.

Dalvance _____mg IV x one dose followed by Dalvance _____mg IV one week later per protocol.

✓ Estimated CrCl of 30mL/min and above or on regular hemodialysis: Recommend single dose regimen of 1500mg or two dose regimen of 1000mg followed one week later by 500mg.

✓ Estimated CrCl of less than 30mL/min and not on regular hemodialysis: Recommend single dose regimen of 1125mg or two dose regimen of 750mg followed one week later by 375mg.

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ Creatinine level within the past 30 days

PRE-MEDICATIONS

Acetaminophen: _____^{Oral} 325mg _____ 500mg _____ 650mg

Loratadine: 10 mg

Cetirizine: 10mg

Diphenhydramine: _____ 25mg _____ 50mg

Famotidine: _____ 20mg _____ 40mg

Ibuprofen: _____ 200mg _____ 400mg _____ 600mg

Ondansetron: _____ 4mg _____ 8mg

Other _____

Dexamethasone: _____^{IV} 4mg _____ 8mg

Diphenhydramine: _____ 25mg _____ 50mg

Famotidine: _____ 20mg _____ 40mg

Methylprednisolone 125mg

Hydrocortisone 100mg

Ondansetron: _____ 4mg _____ 8mg

Other _____

LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

****Surveillance lab ordering, and monitoring is the responsibility of the prescriber****

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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

Dispense as Written:

Substitution Allowed:

Prescriber Name _____

Date _____

Prescriber Name _____

Date _____