TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

TwelveStone HEALTH PARTNERS™

DALVANCE ORDER FORM

Date: ___________________________________

Patient Name: ___________________________________

Date of Birth: ___________________________________

ICD-10 Code: ___________________________________

Allergies: ___________________________________

Weight: __________ lbs OR ___________ kg

Therapy Status

Please check any of the following that apply:

☐ *New Start*

☐ *Continuing Therapy:*

Last Dose: ______________________

Provider Information

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

Oral

☐ Acetaminophen: ___325mg ___500mg __650mg
☐ Loratadine: 10 mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: ___25mg ___50mg
☐ Famotidine: ___20mg ___40mg
☐ Ibuprofen: ___200mg ___400mg ___600mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_________________________

IV

☐ Dexamethasone: ___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)

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

OTHER REQUIRED DOCUMENTATION

(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:

________________________________ __________
Prescriber Name Date

Substitution Allowed:

________________________________ __________
Prescriber Name Date

V 6.24.22