TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: referral@12stonehealth.com

DALBAVANCIN ORDER FORM

Patient Name: _____ ICD-10 Code: _____

Date of Birth: _____ Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

DALBAVANCIN	☐ Dalbavancin 1,500mg IV x one dose per protocol. ☐ Dalbavancin 1,125mg IV x one dose per protocol. ☐ Dalbavancin 1,000mg IV x one dose, followed by 500mg IV one week later. ☐ Dalbavancin 750mg IV x one dose, followed by 375mg one week later per protocol. ☐ Dalbavancin _____ mg IV x one dose, followed by _____ mg one week later per protocol.	✓ Estimated CrCl of 30mL/min and above or on regular hemodialysis: Recommend single dose regimen of 1500mg IV OR two dose regimen of 1000mg IV for one dose followed by 500mg IV one week later.	***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 last 30 days

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg
- ☐ Loratadine: 10mg
- ☐ 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 the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

_____ _____

Prescriber Signature Date