

Patient Name: _____

DOB: _____ Wt(kg): _____

Allergies: _____ Phone: _____

Dalvance (Dalbavancin) Infusion Orders

Required Information:

Signed order from prescribing provider

Patient demographics including insurance information

Supporting clinical documentation: Visit notes, lab & imaging results

Primary Diagnosis:

_____ (ICD-10: _____)

Other: _____ (ICD-10: _____)

DALVANCE ORDERS

Single dose regimen

Dalvance 1500 mg in D5W, total volume 300ml

Dalvance 1125 mg in D5W, total volume 225ml

Two dose regimen

Dalvance 1000 mg in D5W, total volume 200ml.

Followed 1 week later by 500mg in D5W, total volume 100ml.

Dalvance 750 mg in D5W, total volume 200ml.

Followed 1 week later by 375mg in D5W, total volume 100ml.

Alternative Dosing

Dalvance 1000 mg in D5W, total volume 200ml.

Followed once weekly by 500mg in D5W, total volume 100ml, for 6 weeks.

Dalvance 750 mg in D5W, total volume 200ml.

Followed once weekly by 375mg in D5W, total volume 100ml, for 6 weeks.

Sig: Infuse 1 dose over 1 hour via peripheral line. Unless otherwise specified.

Sig: _____

Additional orders: Include anaphylaxis kit with first dose.

ADDITIONAL INSTRUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

Physician Name:

Phone:

Fax:

Physician Signature:

NPI:

Date: