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ORBACTIV (ORITAVANCIN) INFUSION ORDERS

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes** supporting primary diagnosis
- Most Recent Lab Results

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- _____ (ICD-10: _____)
- _____ (ICD-10: _____)

ORBACTIV ORDERS

1200mg IV over three hours x 1 dose

Other: _____

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	NPI:	Date: