

Birmingham, AL
F: 205-271-9971Huntsville, AL
F: 256-417-6408Knoxville, TN
F: 865-934-0249Nashville, TN
F: 615-645-4791Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
Phone Number: _____ Email Address: _____
Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including BUN & Creatinine

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: DALVANCE® (dalbavancin)*Administer 1,500 mg Dalvance IV as a one-time dose over 30 minutes**Administer 1,000 mg Dalvance IV over 30 minutes and then 500 mg Dalvance IV over 30 minutes one week later***Dose adjustment for CrCl < 30 ml/hr (Select one)**

Administer 1,125mg Dalvance IV as a one-time dose over 30 minutes OR

Administer 750mg Dalvance IV over 30 minutes and then 375mg Dalvance IV over 30 minutes one week later

Other: _____**Pre-Medication Orders:** No Pre-Meds recommended**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRx to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#_____
Physician's Address_____
Prescriber's Signature_____
Date