INTRAMED Plus
infusion services

DALVANCE®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Recent laboratory results including BUN & Creatinine

Patient
Weight: _____ lbs.
Height: _____ in.

DALVANCE® (dalbavancin) J Code: J0875

4. Drug Order:

❑ 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 Davlance IV over 30 minutes one week later

❑ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

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

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	**COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

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