**Cumberland Vital Care**
**Fax Referral To:**
**(931) 456-4587**
Direct Phone: (931) 456-0680

# DALVANCE ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

## Therapy Status

*Please check any of the following that apply:*

☐ *New Start*
☐ *Continuing Therapy:*
*Last Dose:* _____

## Provider Information

Ordering Provider: _____
Provider NPI: _____
Provider Phone: _____
Provider Fax: _____
Provider Address: _____

## MEDICATION ORDER

☐ Dalvance

☐ Dalvance 1,500mg IV x one dose per protocol.
☐ Dalvance 1,125mg IV x one dose per protocol.
☐ Dalvance 1,000mg IV x one dose, followed by 500mg IV one week later per protocol.
☐ Dalvance 750mg IV x one dose, followed by 375mg one week later per protocol.
☐ Dalvance _____mg IV x one dose followed by Dalvance _____mg IV one week later per protocol.

✓ *Estimated CrCl of 30mL/min and above or on regular hemodialysis: Recommend single dose regimen of 1500mg or two dose regimen of 1000mg followed one week later by 500mg.*

✓ *Estimated CrCl of less than 30mL/min and not on regular hemodialysis: Recommend single dose regimen of 1125mg or two dose regimen of 750mg followed one week later by 375mg.*

**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 past 30 days*

## PRE-MEDICATIONS

Oral
☐ Acetaminophen: ___325mg ___500mg __650mg
☐ Loratadine: 10 mg
☐ 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 Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

**By signing below, I certify that above therapy is medically necessary Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

V 6.24.22