

DALVANCE[®] Referral Form



Fax Completed Form To:

Phone:

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Diagnosis & ICD-10:		
Allergies:		
PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:	NPI#:	
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		
PLEASE ATTACH		
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical) <input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results <input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates) <input type="checkbox"/> Line access documentation/verification if applicable		<input type="checkbox"/> Estimated creatinine clearance <input type="checkbox"/> Culture & sensitivity results <input type="checkbox"/> Letter of medical necessity if drug dosing or indication is outside of FDA guidelines
NURSING & LAB ORDERS		
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - <input type="checkbox"/> 10units/mL --- OR --- <input type="checkbox"/> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:		
PRESCRIPTION ORDERS		
Anaphylaxis Kit: <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-Cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other		
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary		
PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> DALVANCE <i>(to be mixed in DSW)</i>	Adult Dosing: Estimated Creatinine Clearance 30mL/min and above or on regular hemodialysis: <input type="checkbox"/> 1500mg single dose regimen or <input type="checkbox"/> 1000mg followed by one week later 500mg two dose regimen IV infusion via <input type="checkbox"/> gravity --- OR --- <input type="checkbox"/> pump over 30 minutes Less than 30mL/min and not on regular hemodialysis: <input type="checkbox"/> 1125mg single dose regimen or <input type="checkbox"/> 750mg followed by one week later 375mg two dose regimen IV infusion via <input type="checkbox"/> gravity --- OR --- <input type="checkbox"/> pump over 30 minutes	_____ _____
<input type="checkbox"/> OTHER		_____ _____
By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.		

Prescriber's Signature <u>Dispense as Written</u>	Print Name	Date	Prescriber's Signature <u>Substitution Permitted</u>	Print Name	Date
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ACHC ACCREDITED

