DALVANCE® Referral Form

Fax Completed Form To: **Phone:**

amerita
specialty infusion services

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ 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

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Line access documentation/verification if applicable
- ☐ Estimated creatinine clearance
- ☐ Culture & sensitivity results
- ☐ 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* - ☐ 10units/mL ***---OR---*** ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line

Lab Orders: **Lab Date & Frequency:**

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed
☐ Diphenhydramine _____ mg IV infusion as needed
☐ Solu-Cortef 250mg-500mg IV infusion as needed
☐ NS Hydration 500 ml IV infusion over 30 minutes as needed
☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ 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? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____		
☐ DALVANCE *(to be mixed in DSW)*	Adult Dosing: Estimated Creatinine Clearance 30mL/min and above or on regular hemodyalysis: ☐ 1500mg single dose regimen or ☐ 1000mg followed by one week later 500mg two dose regimen IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes Less than 30mL/min and not on regular hemodialysis: ☐ 1125mg single dose regimen or ☐ 750mg followed by one week later 375mg two dose regimen IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes	_____
☐ 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 **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

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ACHC ACCREDITED
PCAB ACCREDITED Compounding Pharmacy