

# DALVANCE<sup>®</sup> Referral Form

Fax Completed Form To: 877-418-4495 Phone: 877-418-4114



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
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> 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 <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	Epinephrine 0.3mg IM as needed	Solu-Cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____ mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes 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 <i>(to be mixed in DSW)</i>	Adult Dosing: Estimated Creatinine Clearance 30mL/min and above or on regular hemodialysis: 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 \_\_\_\_\_  
 Dispense as Written \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Date \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_  
 Substitution Permitted \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Date \_\_\_\_\_



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