

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		_____
<i>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.</i>		

Prescriber's Signature	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		