IV Antimicrobials

Provider Order Form Rev. 05/2024

Please fax completed referral form & all required documents to (833) 786-0025

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ ______________________, ICD10 ___________ ☐ ______________________, ICD10 ___________

INFUSION ORDERS

MEDICATION	DOSE/DIRECTIONS/DURATION
☐ Dalvance® (dalbavancin)	**Single-dose regimen** ☐ Infuse 1500mg IV over 30-60 minutes x 1 dose ☐ Infuse 1125mg IV over 30-60 minutes x 1 dose **Two-dose regimen** ☐ Infuse 1000mg IV over 30-60 minutes once followed by 500mg IV over 30-60 minutes one week later ☐ Infuse 750mg IV over 30-60 minutes once followed by 375mg IV over 30-60 minutes one week later ☐ Other: ______________________
☐ Kimyrsa® (oritavancin)	☐ Infuse 1200mg IV over 90-120 minutes x 1 dose ☐ Other: ______________________
☐ Rezzayo™ (rezafungin)	☐ Infuse 400mg IV over 1 hour x 1 dose, followed by 200mg IV over 1 hour once weekly x 3 doses ☐ Other: ______________________

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: ______________________ Date of last treatment: ____________ Date of next treatment: ____________

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time ☐ Other: ______________________

☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________ ☐ CK q _________ ☐ ESR q _________ ☐ LFTs q _________

ADDITIONAL ORDERS: ______________________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ NPI:__________ TIN:__________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

☐ Culture and sensitivity report

☐ Creatinine clearance (CrCL) for Dalvance®

☐ Other: ______________________