IV Antimicrobials

Provider Order Form Rev. 04/2024

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

HEALIX INFUSION CARE

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 (CrCL ≥ 30 mL/min) ☐ Infuse 1125mg IV over 30-60 minutes x 1 dose (CrCL < 30 mL/min) **Two-dose regimen** ☐ Infuse 1000mg IV over 30-60 minutes once followed by 500mg IV over 30-60 minutes one week later (CrCL ≥ 30 mL/min) ☐ Infuse 750mg IV over 30-60 minutes once followed by 375mg IV over 30-60 minutes one week later (CrCL < 30 mL/min) ☐ 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: _____ Provider NPI: _____ 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: _____