DALVANCE (dalbavancin) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Rqd.)* ☐ Verify Benefits Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

_____

Office Contact: _____

Phone # & Ext.: _____ _____ Fax #: _____

Direct Message Address _____

DALVANCE MEDICATION ORDERS

Dosing: IV 30 min infusions

Patient Weight: _____kg

☐ 1000mg initial followed 1 week later by 500mg

☐ 750mg initial followed 1 week later by 375mg ☐ Other _____

DIAGNOSIS/INDICATION

☐ ABSSI caused by MSSA

☐ ABSSI caused by MRSA

☐ Other _____

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____

Ordering Provider's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

PLEASE ATTACH THE FOLLOWING REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ CrCl

☐ ALT

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY