

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:	☐ 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		
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 - ☐ 10units/mL ---OR--- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:		
PRESCRIPTION ORDERS		
Anaphylaxis Kit: ☐ 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 (to be mixed in DSW)	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		_____
<i>By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.</i>		

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



ACHC
ACCREDITED

