LIFEBRIDGE HEALTH
CARE BRAVELY

DALBAVANCIN (Dalvance®)
ORDER FORM

Patient Name: _____ DOB: _____

Allergies: _____ Height (cm): _____ Weight (kg): _____

Diagnosis: _____ Diagnosis Code: _____

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Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.

- ☐ Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- ☐ Demographics / insurance information attached, or available in Cerner.
- ☐ Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: _____

LifeBridge Health Criteria for Use:

Please review and ensure that the patient meets the following criteria:

Indication for treatment:

- ☐ Joint infection
- ☐ Osteomyelitis
- ☐ Bacteremia/Endocarditis
- ☐ Skin/Soft tissue infection

Treatment:

☐ Dalbavancin 1,500 mg in 250 mL D5W IV over 30 minutes once

OR

☐ Dalbavancin 1,500 mg in 250 mL D5W IV over 30 minutes Day 1 and Day 8 *(considered equivalent to 6-week course of therapy)*

Protocol Orders:

☒ Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.

☒ Extravasation Management: Follow established protocol for extravasation as needed.

☒ Port Care and Flush per Nursing Protocol: Single-lumen flush protocol or double-lumen flush protocol as appropriate.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

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