VIVO infusion
FORMERLY IDC INFUSION

DALVANCE (dalbavancin)

FAX TO (216) 378-9824
FOR QUESTIONS, CALL (216) 488-1060

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Allergies: _____ Ht (in): _____ Wt (kg): _____ Gender: M | F

Demographic Information Attached: ◯ **Yes**

Insurance Information Attached (front and back of card): ◯ **Yes**

Infusion location: ◯ Beachwood ◯ Painesville ◯ Fairlawn ◯ Westlake ◯ Middleburg Heights ◯ Youngstown

Patient Status: ◯ New to Therapy
◯ Order Renewal
◯ Change of Dose | Frequency
◯ Continuing Treatment | Transfer from a Prior Site of Care. Next Treatment Due Date: _____
(Efforts will be taken to maintain treatment schedule, but next due date cannot be guaranteed)

2 CLINICAL INFORMATION

ICD-10 Code (required & as specific as possible): _____ ICD-10 Description: _____

Clinical/Progress Notes, Labs, Tests Supporting Primary Diagnosis Attached: ◯ Yes

3 INFUSION ORDER

Dalvance: ◯ 1500 mg IV 1 time only
◯ 1000 mg IV followed by 500 mg IV one week later

Renal dosing for Creatinine clearance <30 mL/min and not on regular hemodialysis:
◯ 1125 mg IV one time only
◯ 750 mg IV followed by 375 mg IV one week later

Other dosing: _____

Labs requested: ◯ Yes ****MUST ATTACH SIGNED LAB REQUISITION TO THIS REFERRAL FORM****
Frequency _____
Fax results to: _____
◯ No

INFUSIONS WILL BE ADMINISTERED PER VIVO INFUSION CENTER POLICY AND PROTOCOLS.

4 PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Office Contact: _____ Email: _____

Prescriber Signature: _____ Date: _____

FOR MORE INFORMATION OR TO ACCESS REFERRAL FORMS, VISIT OUR WEBSITE AT VIVOINFUSION.COM