

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Relevant labs and tests including:
 - Culture and sensitivity data
 - Recent labs including BUN & Creatinine
- Medication List

Height: _____

Weight: _____

Dalvance (dalbavancin) Orders:

- ☐ Administer 1,500 mg Dalvance intravenously as a single dose over 30 minutes
- ☐ Administer 1,000 mg Dalvance intravenously over 30 minutes followed by 500 mg Dalvance intravenously over 30 minutes one week later

Dose Adjustment for CrCl <30 mL/hour:

- ☐ Administer 1,125 mg Dalvance intravenously as a single dose over 30 minutes
- ☐ Administer 750 mg Dalvance intravenously over 30 minutes followed by 375 mg Dalvance intravenously over 30 minutes one week later

☐ Other: _____

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus

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