

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment:**Diagnosis (ICD-10):****Allergies:******Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis******Pre-Medication Orders:**

- ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg - PO 30 minutes before infusion OR ☐ 25mg IVP ☐ 50mg IVP
- ☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
- ☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP OR other _____ mg IVP
- ☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
- ☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider**Medication****Cabenuva (Cabotegravir / Rilpivirine)**

Once a Month Dosing Regimen:

- ☐ Induction: Cabenuva 600mg/900mg IM x 1 dose.
- ☐ Maintenance: Cabenuva 400mg/600mg IM monthly thereafter.

Refills: _____

Every Two Month Dosing Regimen:

- ☐ Induction: Cabenuva 600mg/900mg IM once a month x 2 doses.
- ☐ Maintenance: Cabenuva 600mg/900mg IM every 2 months thereafter.

Refills: _____

Dalvance (dalbavancin)

Dosage / Frequency: (based on CrCl)

Single Dose Regimen:

- ☐ Dalvance 1500 mg IV (>30 ml/min CrCl)
- ☐ Dalvance 1125 mg IV (<30 ml/min CrCl)

Two Dose Regimen:

- ☐ Dalvance 1000 mg IV followed one week later by 500 mg IV (>30 ml/min CrCl)
- ☐ Dalvance 750 mg IV followed one week later by 375 mg IV (<30 ml/min CrCl)

Orbactiv (oritavancin)

Dosage / Frequency:

- ☐ Orbactiv 1200 mg IV x 1 single dose.

Physician Prescription Orders

Address: _____ Phone: _____ Fax: _____

Clinic Contact: _____ Physician Name: _____

NPI # _____ Physician Signature: _____ Date: _____