McLeod Health

Place Sticker Here

Dalbavancin (Dalvance) Treatment Plan

Patient Name: _____ DOB: _____

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

Serum creatinine (mg/dL): _____ Date of lab: _____ CrCl (mL/min): _____ or ☐ ESRD on scheduled HD

Appropriate use criteria: Patient must meet all of the below criteria to be considered eligible for dalbavancin

☐ At least 18 years of age

☐ Requires antibiotics for an acute bacterial skin and skin structure infection (ABSSSI) without suspicion for or known current deep-seated infections such as osteomyelitis or endocarditis

☐ Has failed oral antibiotics OR infection severity precludes use of oral antibiotics OR there is concern for poor adherence to an oral antibiotic regimen

Diagnosis (select one ICD-10 code):

☐ A49.0 Staphylococcal infection, unspecified site

☐ A49.01 Methicillin-susceptible *Staphylococcus aureus* infection, unspecified site

☐ A49.02 Methicillin-resistant *Staphylococcus aureus* infection, unspecified site

☐ A49.1 Streptococcal infection, unspecified site

☐ L03.90 Cellulitis, unspecified

☐ Other ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Dalbavancin (Dalvance) (J0875) per 500 mL D5W IV to infuse over 30 minutes
- Dose: ☐ CrCl ≥ 30 mL/min or on scheduled hemodialysis: 1500 mg x 1 dose
  ☐ CrCl < 30 mL/min: 1125 mg x 1 dose
- Other dose: _____

Lab Orders:

☐ Blood culture x 2 sets, collect from separate sites prior to administering dalbavancin

☐ Comprehensive metabolic panel (CMP) prior to administering dalbavancin

☐ _____

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Please send history and physical and most recent physician note with completed plan. Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)