Care Fusion INFUSION CENTERS

AIC Infectious Disease

Fax: 855-733-9898
Phone: 877-460-3905

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:*** _____