aleracare
advanced infusion centers™

Orbactiv (oritavancin)

Provider Order Form rev. 5/20/2022

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Next Due Date (if applicable):

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

Documentation (Required)

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ A49.1 Streptococcal infection ◯ A49.01 Staphylococcus infection, methicillin susceptible

◯ A49.02 Staphylococcus infection, methicillin resistant ◯ A49.8 Other bacterial infections ◯ Other: _____

Medication Order

Orbactiv (oritavancin) **Dose:** ◯ 1,200mg IV **Frequency:** ◯ once

Special Instrustions

Provider Name **Provider Signature** **Date**