MATAGORDA REGIONAL
MEDICAL CENTER

MRMC IV THERAPY SERVICES
Phone: 979-241-5966
Fax: 979-241-5965

Oritavancin IV

PATIENT INFORMATION

Last Name: ________________________ First Name: ________________________ MI_______ DOB:_______________

HT: ______ WT: ______ Sex :( ) Male ( ) Female SSN:_______________________ Home #:_______________________ Cell#:_____________________

Street Address____ City/State/Zip ____

Allergies:____

INSURANCE INFORMATION

Primary Insurance Name____ Policy ID #__________________________

Secondary Insurance Name____Policy ID #___________________________

PHYSICIAN / FACILITY INFORMATION

Physician Name______________________________________ Contact Name _____________________ Contact Phone # _________________________

Address: ____City/State/Zip____

DEA#:________________________ NPI #:_______________________ State Lic #:_______________ Fax #: ____________________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

____ **Date of Diagnosis:** __________________

PRESCRIPTION ORDERS (Kimyrsa is the formulary preferred agent; Orbactiv will be used only if Kimyrsa is unavailable)

For Acute Bacterial Skin and Skin Structure Infections (ABSSSI):

◯ Oritavancin 1200 mg IVPB x 1 dose

OFF-LABEL Indications:

For Osteomyelitis treatment:

◯ Oritavancin 1200 mg IVPB x 1 dose, then 800 mg IVPB once per week x 3 doses (>6 days between each dose)

◯ Oritavancin as follows:____

For Infective Endocarditis treatment:

◯ Oritavancin 1200 mg IVPB once weekly x 6 weeks (>6 days between each dose)

Prior to infusion, administer Benadryl IV or PO (check one)				
	Medication	**Dose**	**Route**	**FREQUENCY**
	Benadryl	25 mg	IV	Once
	Benadryl	50 mg	PO	Once

Physician's Signature ____**Time**_________________ **Date**______________

Fax completed form to the MRMC Infusion Center at (979) 241-5965. PLEASE include copies of: ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed. **Reviewed 04/2026**