Dalvance® Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

DALRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis: _____
ICD10: _____

History of therapies tried/failed (please include dates):

Estimated CrCl:_____mL/min

Prescribed dosing regimen of DALVANCE® (dalbavancin) for injection:
First Dose: _____(mg) Date of First Dose: ____ / ____ / ____
Site of Administration for First Dose:
Administering Physician for First Dose:

Second Dose:_____(mg)
Is second dose scheduled? ☐ Yes ☐ No
If Yes, date of second dose: ____ / ____ / ____
Expected Discharge Date (if applicable): _____

Immunization History
☐ Influenza
Date: ____ /____ / ____

Culture Results:

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Dalvance®** (dalbavancin)	☐ 500 mg/vial			

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____