DALVANCE CONNECTS®

Dalvance Connects® Copay Assistance Program Enrollment Form for Healthcare Professionals

Please complete the form, sign, and fax to 1-855-888-7206.
For assistance, call Dalvance Connects® at 1-855-387-2824,
Monday through Friday from 8 AM to 8 PM ET.

Services Requested

Please check all that apply: ☐ Benefits Verification ☐ Prior Authorization Assistance ☐ Claims Assistance ☐ Copay Assistance Program

Patient Information

Last Name:	First Name:
Address:	City: State: ZIP Code:
Date of Birth:	Gender: ☐ Female ☐ Male
Primary Phone: ( )	Secondary Phone: ( )
Email:	
Alternate Contact Name:	Phone: ( ) Relationship to Patient:

Insurance Information (please attach copy of front and back of insurance card[s])

PRIMARY Insurance Name:	SECONDARY Insurance Name:
Phone:	Phone:
Policy ID #:	Policy ID #:
Group #:	Group #:
Policyholder Name:	Policyholder Name:
Policyholder Date of Birth:	Policyholder Date of Birth:
Relationship to Patient:	Relationship to Patient:

Diagnosis and Treatment

Patient diagnosis including code:

Prescribed dosing regimen of DALVANCE® (dalbavancin) for injection:
First Dose: _____ (mg) Date of First Dose: _____ / _____ / _____
Second Dose: (mg) Is second dose scheduled? ☐ Yes ☐ No If yes, date of second dose: _____ / _____ / _____

Physician Information

Prescriber's First Name:	Prescriber's Last Name:	
Practice/Facility Name:	Specialty:	
Address:	City: State:	ZIP Code:
Office Contact Name:	Phone: ( )	Fax: ( )
Prescriber Tax ID:	Prescriber NPI:	Group NPI:

Site of administration: ☐ Physician's office ☐ Hospital outpatient ☐ Freestanding Infusion Clinic ☐ Other: _____

(If administration site is different than the address listed directly above, please complete the following)

Administering Practice/Facility Name:		
Administering Physician First Name:	Administering Physician Last Name:	
Address:	City: State:	ZIP Code:
Administering Office Contact:	Phone: ( )	Fax: ( )
Administering Site Tax ID:	Administering Site NPI:	

Specialty Pharmacy

Are you interested in acquiring medication through a specialty pharmacy? ☐ Yes ☐ No
If yes, please list any preferred specialty pharmacies: _____

Physician Declaration (signature required for all services)

I certify DALVANCE® is medically necessary and is being prescribed for the patient listed above based on my independent clinical judgment. I have supplied the program operated by the Lash Group, an agent of AbbVie, this information in order for them to coordinate access to treatment for my patient. I certify that the patient named above has authorized the release and disclosure of the information contained within this enrollment form for the purposes of investigating and resolving insurance coverage, coding or reimbursement questions.

Physician Signature (no stamps):	
Name (print):	
Date:	

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