DALVANCE CONNECTS℠

Enrollment Form

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 Eastern Time.

Services Requested

Please check all that apply: ☐ Benefits Verification ☐ Prior Authorization Assistance ☐ Claims Assistance ☐ Copay Assistance
☐ Patient Assistance Program (PAP) for Uninsured Patient (Patient must review, complete and sign page 2 for PAP services.)

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:_____ /_____ /_____

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:_____ /_____ /_____

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 ☐ Free-standing 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 Allergan, 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. Should this patient qualify for free product through the program, I acknowledge and agree not to submit a claim for payment to the patient or any third-party payor for the medication received. Nor will the medication received be resold or offered for sale, trade or barter and will not be returned for credit.

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

Please complete the form, sign, and FAX to 1-855-888-7206

Only Required for Patients Enrolling in the Patient Assistance Program

DALVANCE CONNECTS℠

Patient Assistance Program Patient Attestation

Patients applying for the Patient Assistance Program must review, complete and sign the Patient Attestation and Authorization below. The completed form should be faxed with Page 1 to 1-855-888-7206. For assistance with any questions, call 1-855-387-2824, Monday through Friday from 8 AM to 8 PM Eastern Time.

Patient Attestation and Authorization
REQUIRED for Patient Assistance Program (PAP) Applicants Only

Annual pre-tax household income: _____ **Number of family members living in household:** _____

I attest that the above household income and number of family members listed above is complete and accurate. In addition, I attest that I am not currently enrolled in a government-funded healthcare program. I agree that at any time during my enrollment in the DALVANCE CONNECTS℠ Patient Assistance Program (PAP), additional documentation to authenticate the statements made on my application may be required. If requested, this information will only be used to determine eligibility for PAP. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. Please note that this program does not constitute health insurance.

Patient Signature:

Name (print):

Date: _____/_____/_____

PATIENT Sign Here