PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Dalvance (Dalbavancin) - Referral Form

Send referral to RE Pharmacy location. Choose below (optional)

Date Medication Needed: _____/_____/_____ Injection training by pharmacy? ☐

Ship to: ☐ Patient's Home ☐ Prescriber's Office Pick-up (store location): _____

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical)

Patient Name: _____ Gender: ☐ Male ☐ Female

Height: _____Weight: _____ ☐ lbs. ☐ kg. SS#: _____Birth Date: _____/_____/_____

Preferred Phone: _____ Known Allergies: _____

Address: _____City: _____ State: _____ZIP: _____

Insurance Info: _____ Policy Number: _____

2. PRESCRIBER INFORMATION

Provider Name: _____ DEA#: _____ NPI#: _____TAX ID#: _____

Address: _____ Phone: _____ Fax: _____

City: _____ State: ____ ZIP: _____Key Contact: _____ Phone #: _____

Specialty: ☐ Infectious Disease

3. CLINICAL INFORMATION

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Has patient previously been treated for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Current medications: _____

Will patient stop taking the above medication(s) before the new medication? ☐ Yes ☐ No

DIAGNOSIS:

☐ Osteomyelitis ☐ Acute subcutaneous infection of the skin ☐ MRSA infection of the skin

Other: _____

4. PATIENT MEDICAL HISTORY

☐ Kidney Disease (Crcl: ____ml/min) ☐ Liver Impairment (Please specify: _____)

ALLERGIES:

Please specify: _____

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5. PRESCRIPTION INFORMATION

DOSAGE AND FREQUENCY	
☐	Single dose 1500mg IV over 30 minutes
☐	1000mg IV followed by 500 mg IV 1 week later over 30 minutes
☐	750 mg IV followed by 375mg IV 1 week later over 30 minutes
	Other: _____

Supplies: ☐ D5W Flushes Other(s): _____

5. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____

Patient Signature Date

6. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ _____ _____ _____

Dispense as written Date Substitution Permissable Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

Faxed prescriptions will only be accepted from a prescribing practitioner.
Prescribers are reminded patients may choose any pharmacy of their choice.

#of Prescriptions