OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Dalvance® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acute bacterial skin and skin structure infections

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Will Dalvance be used for the treatment or empirical treatment of acute bacterial skin and skin structure infection? ❑ **Yes** ❑ **No**

Select if the infection is caused by the following bacteria:

- ❑ Methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report
- ❑ Presence of MRSA infection likely
- ❑ Methicillin-susceptible Staphylococcus aureus (MSSA) documented by culture and sensitivity report
- ❑ Streptococcus pyogenes documented by culture and sensitivity report
- ❑ Streptococcus agalactiae documented by culture and sensitivity report
- ❑ Streptococcus anginosus group (including Streptococcus anginosus, Streptococcus intermedius, Streptococcus constellatus) documented by culture and sensitivity report

Select if the patient has the following:

- ❑ Osteomyelitis
- ❑ Diabetic foot infection

Select if the patient has had **trial and failure** to the following antibiotics:

- ❑ Amoxicillin/clavulanate
- ❑ A cephalosporin
- ❑ Ciprofloxacin, ciprofloxacin intravenous solution in D5W
- ❑ Clindamycin, clindamycin phosphate in D5W
- ❑ Dicloxacillin
- ❑ Doxycycline
- ❑ A fluoroquinolone
- ❑ Levofloxacin, levofloxacin in D5W
- ❑ Moxifloxacin
- ❑ Sulfamethoxazole-trimethoprim (SMX-TMP)
- ❑ A tetracycline
- ❑ Other: _____

Select if the patient has history of **resistance, contraindication, or intolerance** to the following antibiotics:

- ❑ Amoxicillin/clavulanate
- ❑ A cephalosporin
- ❑ Ciprofloxacin, ciprofloxacin intravenous solution in D5W
- ❑ Clindamycin, clindamycin phosphate in D5W
- ❑ Dicloxacillin
- ❑ Doxycycline
- ❑ A fluoroquinolone
- ❑ Levofloxacin, levofloxacin in D5W
- ❑ Moxifloxacin
- ❑ Sulfamethoxazole-trimethoprim (SMX-TMP)
- ❑ A tetracycline
- ❑ Other: _____

Dalvance® Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.