PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Dalvance® (dalbavancin)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________ Gender: ______________

Primary Care Physician: ______________________

Requesting Physician: ______________________ Phys. Phone: ______________ Phys. Fax: ______________

Physician Address: ____

Physician NPI: ______________________ Contact Name: ______________________

Physician Signature: ______________________ Date: ______________

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Dalvance 500 mg vial

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Date of next dose (if applicable): ______________

Dose:__________ **Dose Frequency**:______________

Height: _______ **Weight**: _______ **Body Surface Area**:_______

☐ Prescriber is an infectious disease specialist

☐ Prescriber consulted with an infectious disease specialist

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: ______________ NPI:______________ Fax:______________

☐ Home infusion

Facility: ______________ NPI:______________ Fax:______________

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty pharmacy:

Pharmacy: ______________ NPI:______________ Fax:______________

ICD-10 Diagnosis code(s): ______________________

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2018

PriorityHealth

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be age 18 or older
2. Fax a copy of culture and sensitivity results to Priority Health showing the patient's infection is not susceptible to alternative antibiotic treatments
3. Dalvance must be started in the hospital or other health care facility and will be continued in outpatient facility
4. Must have documented methicillin-resistant *Staphylococcus aureus* (MRSA) acute bacterial skin and skin structure infection (ABSSSI) that is resistant to all other MRSA sensitive antibiotics or be unable to tolerate alternatives.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ ABSSSI
- ☐ Other – the patient's condition is: ______________________

B. Was a culture completed?

- ☐ Yes. The result was: ______________________
- ☐ No – rationale for use: ______________________

C. Was antibiotic susceptibility determined?

- ☐ Yes (fax results with this prior authorization request)
  Note: susceptibility results must show infection is not susceptible to alternative antibiotics
- ☐ No – rationale for use: ______________________

D. Was Dalvance started in the hospital (or other health care facility)?

- ☐ Yes – How many days of treatment did the patient receive? ______________________
- ☐ No

E. What other antibiotics were previously used that were not successful in treating the patient's current infection?

☐ Yes, other drugs used include:

Drug: ______________ Date: __________ Outcome: ______________
Drug: ______________ Date: __________ Outcome: ______________
Drug: ______________ Date: __________ Outcome: ______________

☐ No other antibiotics have been used for the patient's current infection

F. Is the patient being treated for a MRSA infection?

☐ Yes, and
- ☐ All other susceptible antibiotics have already been tried
- ☐ Patient is unable to tolerate other susceptible antibiotics because: ______________________
- ☐ Patient has a documented allergy to susceptible antibiotics that have not been tried
- ☐ Other rationale: ______________________

☐ No – rationale for use: ______________________

Additional information

For requests that do not meet Priority Health's precertification requirements, prescribers are encouraged to include medical records, other supporting documents, or statements to establish medical necessity and rationale for an exception to the coverage requirements.

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Last reviewed 09/2018