

Darzalex® (daratumumab) and Darzalex Faspro® (daratumumab/hyaluronidase-fihj)
Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information

Multiple Myeloma

- A. Will daratumumab be used in combination with **lenalidomide and dexamethasone** as primary therapy for a member who is ineligible for autologous stem cell transplant (ASCT)? Yes No
- B. Will daratumumab be used in combination with **lenalidomide and dexamethasone** after at least 1 prior therapy? Yes No
- C. Will daratumumab be used in combination with **bortezomib, melphalan, and prednisone** as primary therapy for a member who is ineligible for ASCT? Yes No
- D. Will daratumumab be used in combination with **bortezomib, thalidomide, and dexamethasone** as primary therapy for a member who is eligible for ASCT? Yes No
- E. Will daratumumab be used in combination with **bortezomib, lenalidomide, and dexamethasone** as primary therapy for a member who is eligible for ASCT? Yes No
- F. Will daratumumab be used after at least 1 prior therapy in combination with 1 of the following therapy combinations listed below? Yes No If yes, please indicate which therapy combination will be used:

- dexamethasone and bortezomib
- carfilzomib and dexamethasone
- dexamethasone and lenalidomide
- cyclophosphamide, bortezomib, and dexamethasone
- pomalidomide and dexamethasone*

*For this combination, does previous therapy include lenalidomide and a proteasome inhibitor (PI)?

Yes No

Other: _____

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<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria**For Initial Authorization:****1. Please indicate the diagnosis and information:** **Multiple Myeloma** (continued)

- G. Will daratumumab be used in combination with **lenalidomide and dexamethasone** after at least 1 prior therapy? Yes No
- H. Will daratumumab be used in combination with **cyclophosphamide, bortezomib, and dexamethasone** as primary therapy? Yes No
- I. Will daratumumab be used for disease relapse after 6 months following primary induction therapy with the same regimen? Yes No
- J. Will daratumumab be used as a single-agent after ≥ 3 prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent, or double refractory to a PI and an immunomodulatory agent? Yes No

 Light Chain Amyloidosis

- A. Will daratumumab be used as a single-agent in relapsed or refractory disease? Yes No
- B. Will daratumumab be used in combination with bortezomib, cyclophosphamide, and dexamethasone for newly diagnosed disease? Yes No

 Smoldering Myeloma

- A. Is diagnosis high-risk smoldering myeloma (asymptomatic)? Yes No
- B. Will daratumumab be used as a single agent? Yes No

 Other: _____**Additional Information:** _____**For Continued Authorization:**

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on daratumumab? Yes No
3. Has the member experienced adverse drug reactions related to daratumumab therapy? Yes No

If yes, please specify adverse reactions: _____

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Prescriber Signature: _____ **Date:** _____**I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.** Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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