



Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462
 (800.88.CIGNA)

Darzalex (daratumumab) Darzalex Faspro (daratumumab; hyaluronidase-fihj)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication Requested: <input type="checkbox"/> Darzalex 100mg/5ml <input type="checkbox"/> Darzalex 400mg/20mg <input type="checkbox"/> Darzalex Faspro 1800mg/30,000 units Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ What is your patient's current weight? _____ lbs or kg (circle one) ICD10: _____ Is this a new start? Yes <input type="checkbox"/> No <input type="checkbox"/> Start Date: : _____ (if continued therapy) What week of therapy is your patient currently at? _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy <i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____ <p style="text-align: center;">NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting</p> Is this infusion occurring in a facility affiliated with hospital outpatient setting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale): _____					
Is the patient a candidate for home infusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
(if Darzalex IV) Diagnosis related to use: <input type="checkbox"/> multiple myeloma (MM) <input type="checkbox"/> systemic light-chain amyloidosis <input type="checkbox"/> Other (please specify): _____					
(if Darzalex Faspro) Diagnosis related to use: <input type="checkbox"/> Amyloidosis <input type="checkbox"/> multiple myeloma (MM) <input type="checkbox"/> Other (please specify): _____					

Clinical Information

- (if multiple myeloma) Will the requested drug be used as single agent therapy? Yes No
- (if not single agent) Will the requested drug be used in combination with bortezomib (Velcade), melphalan, and prednisone (VMP)? Yes No
- (if in combo with VMP) When first starting the requested drug, is/was your patient newly diagnosed and NOT eligible for autologous stem cell transplant (auto-SCT)? Yes No
- (if not in combo with VMP) Will the requested drug be used in combination with Velcade AND dexamethasone ONLY? Yes No
- (if not in combo with Velcade and dexamethasone) Will the requested drug be using in combination with Revlimid AND dexamethasone? Yes No
- (if in combo with Revlimid or Velcade AND dexamethasone) Has your patient previously received any chemotherapy for this diagnosis? Yes No
- (if in combo with Revlimid AND dexamethasone, no previous chemo for this diagnosis) When first starting the requested drug, is/was your patient newly diagnosed and NOT eligible for autologous stem cell transplant (auto-SCT)? Yes No
- (if not in combo with VMP OR not with Revlimid or Velcade AND dexamethasone) Will the requested drug be used in combination with Pomalyst AND dexamethasone? Yes No
- (if in combo with Pomalyst and dexamethasone) Has your patient previously received at least 2 prior therapies for multiple myeloma? Yes No
- (if 2 prior therapies) Did your patient ever receive a proteasome inhibitor (PI) (such as Empliciti, Kyprolis, Ninlaro, Velcade) AND Revlimid? Yes No
- (if not in combo with VMP, Revlimid or Velcade or Pomalyst AND dexamethasone) Will the drug requested be used in combination with bortezomib (Velcade), thalidomide and dexamethasone (VTd)? Yes No
- (if with VTD) When first starting the requested drug, is/was your patient newly diagnosed and eligible for autologous stem cell transplant (auto-SCT)? Yes No
- (if not in combo with VTd and requesting IV Darzalex) Will the drug requested be used in combination with carfilzomib (Kyprolis) and dexamethasone? Yes No
- (if IV Darzalex with Kyprolis and dexamethasone) How many prior lines of therapy have been tried for this diagnosis?
- 1
- 2
- 3
- 4 or more
- none or unknown
- (if single agent) Was your patient refractory to BOTH a proteasome inhibitor (Velcade, Kyprolis, Ninlaro, Empliciti) AND an immunomodulatory agent (Revlimid, Pomalyst, Thalomid)? Yes No
- (if no) Has your patient previously received at least prior 3 therapies for multiple myeloma? Yes No
- (if yes) Did your patient ever receive a proteasome inhibitor (PI) (i.e. Empliciti, Kyprolis, Ninlaro, Velcade) AND an immunomodulatory agent (IMiD) (i.e. Pomalyst, Revlimid, Thalomid)?
- Yes, received one from each class of drugs
- No or Unknown
- (if IV form and systemic light-chain amyloidosis) Does your patient have relapsed or refractory disease? Yes No
- (if Faspro and amyloidosis) Prior to starting this medication, is/was your patient considered newly diagnosed? Yes No
- (if Faspro and amyloidosis) Is/Will the requested medication be(ing) used in combination with bortezomib (Velcade), cyclophosphamide and dexamethasone (D-VCd)? Yes No

Additional Pertinent Information: (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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