



Darzalex® (daratumumab) Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: [1-866-752-7021](tel:1-866-752-7021) (TTY: [711](tel:1-866-752-7021))
FAX: [1-888-267-3277](tel:1-888-267-3277)

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:	Last Name: _____ (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:	City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #: DEA #: UPIN:
Provider E-mail:	Office Contact Name:		Phone:

Specialty (Check one): Oncologist Hematologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for Darzalex (daratumumab): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

Multiple myeloma
 What is the prescribed regimen?
 The requested medication in combination with bortezomib, thalidomide, and dexamethasone
 → Yes No Will the requested medication be used for a maximum of 16 doses?
 Yes No Is the patient eligible for transplant?
 Yes No Will the requested medication be used as primary therapy?
 The requested medication in combination with pomalidomide and dexamethasone
 → Yes No Has the patient received at least one prior regimen, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
 The requested medication in combination with bortezomib, lenalidomide and dexamethasone
 → Yes No Is the patient eligible for transplant?
 Yes No Will the requested medication be used as primary therapy?
 The requested medication in combination with carfilzomib, lenalidomide and dexamethasone
 → Yes No Is the patient eligible for transplant?
 Yes No Will the requested medication be used as primary therapy?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed for ALL precertification requests.

- The requested medication in combination with bortezomib, melphalan and prednisone
 - Yes No Is the patient eligible for transplant?
 - Yes No Will the requested medication be used as primary therapy?
- The requested medication in combination with selinexor and dexamethasone
 - Yes No Has the patient been previously treated for multiple myeloma?
- The requested medication in combination with bortezomib and dexamethasone
 - Yes No Has the patient received at least one prior regimen?
- The requested medication in combination with carfilzomib and dexamethasone
 - Yes No Has the patient received at least one prior regimen?
- The requested medication as a single agent
 - Yes No Will the requested medication be used for maintenance therapy?
 - Yes No Is the requested medication being used to treat symptomatic multiple myeloma?
 - Yes No Is the patient a transplant candidate?
 - Yes No Has the patient received at least three prior regimens, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
 - Yes No Is the patient double refractory to a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
- The requested medication in combination with cyclophosphamide, bortezomib, and dexamethasone
- The requested medication will be used in combination with lenalidomide and dexamethasone
 - Yes No Is the patient eligible for transplant?
 - Yes No Will the requested medication be used as primary therapy?
 - Yes No Has the patient received at least one prior regimen?

Other

Systemic light chain amyloidosis

Yes No Is the patient's disease relapsed or refractory?

For Continuation Requests (clinical documentation required for all requests):

Yes No Has the patient experienced disease progression or unacceptable toxicity while on current regimen?
 → Please select: Disease progression Unacceptable toxicity

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.