



MEDICARE FORM

Darzalex Faspro™

(daratumumab and hyaluronidase-fihj) Medication Precertification Request

Page 1 of 2

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

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Darzalex Faspro is non-preferred. The preferred products are Bortezomib and Velcade.

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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms				Allergies:	

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 Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> 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 _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____		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: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	
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E. PRODUCT INFORMATION

Request is for: Darzalex Faspro (daratumumab and hyaluronidase-fihj) 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):

Note: Darzalex Faspro is non-preferred. The preferred products are Bortezomib and Velcade.

Yes No Has the patient had prior therapy with Darzalex Faspro within the last 365 days?

Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

Velcade Bortezomib

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)

Velcade Bortezomib

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Light chain amyloidosis

- Yes No Is the patient newly diagnosed with light chain amyloidosis?
 - Yes No Is the patient's disease relapsed or refractory?
 - Yes No Will the requested drug be used in combination with bortezomib, cyclophosphamide and dexamethasone?

Multiple myeloma

What is the prescribed regimen?

- The requested medication in combination with bortezomib, thalidomide, and dexamethasone
 - Yes No Is the patient eligible for transplant?
 - Yes No Will the requested medication be used as primary therapy?
 - Yes No Will the requested medication be used for a maximum of 16 doses?
- The requested medication 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 one or more prior therapies?
- 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 bortezomib and dexamethasone
 - Yes No Has the patient received at least one prior therapy?
- The requested medication in combination with carfilzomib and dexamethasone
 - Yes No Is the patient's disease relapsed or progressive?
- The requested medication in combination with pomalidomide and dexamethasone
 - Yes No Has the patient received at least two prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent?
- The requested medication as a single agent
 - Yes No Has the patient received at least three prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent?
 - Yes No Is the patient double refractory to a proteasome inhibitor (PI) and an immunomodulatory agent?
- The requested medication in combination with cyclophosphamide, bortezomib, and dexamethasone
- The requested medication will be used 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?
- Other

For Continuation Requests (clinical documentation required for all requests)

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

For light chain amyloidosis only:

- Yes No Will the treatment duration exceed 24 months of treatment?

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.