aetna®

Darzalex™ (daratumumab) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ 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:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

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)

☐ Yes ☐ No Does the patient have a documented diagnosis of multiple myeloma (MM)?
☐ Yes ☐ No Has the patient been newly diagnosed with MM?
→ ☐ Yes ☐ No Will Darzalex (daratumumab) be used in combination with bortezomib, melphalan, and prednisone?
☐ Yes ☐ No Is the patient eligible for autologous stem cell transplant?
☐ Yes ☐ No Will Darzalex (daratumumab) be used for relapsed, progressive, or refractory disease?
→ Please identify: ☐ Relapsed disease ☐ Progressive disease ☐ Refractory disease
☐ Yes ☐ No Has the patient been previously treated?
Please indicate how Darzalex (daratumumab) will be used:

☐ **Single agent**
☐ Yes ☐ No Has the patient received at least 3 prior lines of therapy?
→ Please provide the prior therapies and date ranges used:
Therapy #1: _____ Dates: ____/____/____ - ____/____/____
Therapy #2: _____ Dates: ____/____/____ - ____/____/____
Therapy #3: _____ Dates: ____/____/____ - ____/____/____
☐ Yes ☐ No Was one of the previous therapies a proteasome inhibitor (PI) (e.g., bortezomib, carfilzomib)?
→ Please identify which PI was previously used: ☐ bortezomib ☐ carfilzomib ☐ Other: Name: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

☐ Yes ☐ No Was one of the previous therapies an immunomodulatory agent (e.g., thalidomide,lenalidomide, pomalidomide)?
→ ☐ Yes ☐ No Does the patient have clinical evidence of being double-refractory to a PI and an immunomodulatory agent?
Please identify which immunomodulatory agent was previously used: ☐ thalidomide ☐ lenalidomide ☐ pomalidomide
☐ Other: Name: _____

☐ **In combination with bortezomib and dexamethasone**
☐ Yes ☐ No Has the patient been previously treated?
→ Please indicate: Name: _____ Dates: ___/___/___ - ___/___/___

☐ **In combination with lenalidomide and dexamethasone**
☐ Yes ☐ No Has the patient been previously treated?
→ Please indicate: Name: _____ Dates: ___/___/___ - ___/___/___

☐ **In combination with pomalidomide and dexamethasone**
☐ Yes ☐ No Has the patient received at least 2 prior lines of therapy?
→ Please provide the prior therapies and date ranges used:
Therapy #1: _____ Dates: ___/___/___ - ___/___/___
Therapy #2: _____ Dates: ___/___/___ - ___/___/___
☐ Yes ☐ No Was one of the previous therapies a proteasome inhibitor (PI) (e.g., bortezomib), carfilzomib)?
→ Please identify which PI was previously used: ☐ bortezomib ☐ carfilzomib ☐ Other: Name: _____
Please provide the date range of therapy: Dates: ___/___/___ - ___/___/___
☐ Yes ☐ No Was one of the previous therapies an immunomodulatory agent (e.g., thalidomide, lenalidomide, pomalidomide)?
→ Please identify which immunomodulatory agent was previously used: ☐ thalidomide ☐ lenalidomide
☐ pomalidomide ☐ Other: Name: _____
Please provide the date range of therapy: Dates: ___/___/___ - ___/___/___
☐ Yes ☐ No Has the patient demonstrated disease progression on or within 60 days of completion of the last therapy?

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

Please select how Darzalex (daratumumab) will be used for this continuation request: ☐ In combination use with dexamethasone plus bortezomib
☐ In combination with dexamethasone plus lenalidomide ☐ In combination with pomalidominde and dexamethasone
☐ In combination with bortezomib, melphalan, and prednisone ☐ Single agent
☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on Darzalex (daratumumab)?
→ 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.