



Darzalex Faspro™
(daratumumab and hyaluronidase-fihj)
Medication Precertification Request

Page 1 of 2

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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:		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:		Dispensing Provider/Pharmacy: <i>Patient Selected choice</i>	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

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):

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 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 will be used 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?

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 (continued) – Required clinical information must be completed in its entirety for all precertification requests.

- 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?
- 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 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

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:

How many months has the patient received therapy with the requested medication? _____

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.