



# Darzalex™ (daratumumab) 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:	
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:	Office Contact Name:		Phone:	
Provider E-mail:	Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____			

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <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: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ <b>TIN:</b> _____ <b>PIN:</b> _____
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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 two prior regimens, 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?

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 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 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.