



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: Phone: 1-866-503-0857 FAX: 1-844-268-7263

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

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, Email, Patient Current Weight, Patient Height, and Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Medicare status, Medicaid status, and other coverage details.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, and Office Contact Name.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy details.

E. PRODUCT INFORMATION

Form section E: Product Information. Field for Request is for: Darzalex Faspro (daratumumab and hyaluronidase-fihj) Dose and Frequency.

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Form section F: Diagnosis Information. Fields for Primary ICD Code, Secondary ICD Code, and Other ICD Code.

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

Form section G: Clinical Information. Includes note on preferred products and questions about patient history and medical reasons for not using preferred products.

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?
 - 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.