# Darzalex™ (daratumumab) Medication Precertification Request



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

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021 **(TTY:** 711**)**
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
Please Use Medicare Request Form

**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 #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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 ☐ 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):**

☐ **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 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?

☐ 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 |
|---|---|---|---|
| | | | |

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

- ☐ The requested medication in combination with Ixazomib, 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 venetoclax and dexamethasone
  - → ☐ Yes ☐ No ☐ Unknown Does the patient have a documented t(11:14) translocation?
  - ☐ 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 Will the requested medication be used for maintenance therapy?
    - → ☐ Yes ☐ No Is the requested medication being used to treat symptomatic multiple myeloma?
    - ☐ Yes ☐ No Is the patient a transplant candidate?
  - ☐ 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?
- ☐ The requested medication will be used in combination with lenalidomide
  - → ☐ Yes ☐ No Will the requested medication be used as maintenance therapy?
  - ☐ Yes ☐ No Does the patient have high risk disease?
  - ☐ Yes ☐ No Has the patient been previously treatment for multiple myeloma?
  - ☐ Yes ☐ No Is the patient eligible for transplant?
- ☐ Other

☐ **Systemic light chain amyloidosis**

☐ Yes ☐ No Will the requested medication be used as a single agent?

☐ **T-cell Acute Lymphoblastic Leukemia (T-ALL)**

What is the clinical setting in which the requested medication will be used? ☐ Relapsed disease ☐ Refractory disease ☐ Other_____

What is the prescribed regimen? ☐ The requested medication in combination with vincristine, pegaspargase, doxorubicin, and prednisone or dexamethasone

☐ The requested medication in combination with vincristine, calaspargase, doxorubicin, and prednisone or dexamethasone

☐ Other, please explain:_____

**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.