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

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Darzalex Faspro is non-preferred. The preferred product is bortezomib.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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 #: _____
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 Email:		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 _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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

E. PRODUCT INFORMATION

Request is for: ☐ **Darzalex Faspro (daratumumab and hyaluronidase-fihj)**
Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

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 Initiation Requests (clinical documentation required for all requests):

Note: Darzalex Faspro is non-preferred. The preferred product is bortezomib.

☐ Yes ☐ No Has the patient had prior therapy with Darzalex Faspro within the last 365 days?
☐ Yes ☐ No Will Darzalex Faspro be used in combination with bortezomib?
☐ Yes ☐ No Will Darzalex Faspro be used in combination with lenalidomide and dexamethasone for treatment of a non-transplant eligible member?
☐ Yes ☐ No Has the patient had a trial and failure of bortezomib?
→ When was the member's trial and failure of bortezomib? _____
→ Please describe the nature of the failure of bortezomib _____
☐ Yes ☐ No Has the patient had an adverse reaction to bortezomib?
→ When was the member's adverse reaction to bortezomib? _____
→ Please describe the nature of the adverse reaction to bortezomib _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use bortezomib when indicated for the patient's diagnosis?

_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

☐ **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?
  - → Please select: ☐ 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.