Darzalex Faspro® (daratumumab and hyaluronidase-fihj) 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:		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 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 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 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?

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

☐ **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

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 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 Is the patient eligible for transplant?
  - ☐ Yes ☐ No Will the requested medication be used to treat symptomatic multiple myeloma?
- ☐ 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.