OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Darzalex® (Daratumumab) and Darzalex Faspro® (Daratumumab/Hyaluronidase-fihj) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Physician billing (HCPCS code: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. Please indicate the diagnosis and information

☐ **Light Chain Amyloidosis**

A. Will daratumumab be used as a single-agent in relapsed or refractory disease? Yes☐ No☐

B. Will daratumumab be used in combination with bortezomib, cyclophosphamide, and dexamethasone for newly diagnosed disease? Yes☐ No☐

☐ **Multiple Myeloma**

A. Will daratumumab be used in combination with **lenalidomide and dexamethasone** as primary therapy for a member who is ineligible for autologous stem cell transplant (ASCT)? Yes☐ No☐

B. Will daratumumab be used in combination with **lenalidomide and dexamethasone** after at least 1 prior therapy? Yes☐ No☐

C. Will daratumumab be used in combination with **bortezomib, melphalan, and prednisone** as primary therapy for a member who is ineligible for ASCT? Yes☐ No☐

D. Will daratumumab be used in combination with **bortezomib, thalidomide, and dexamethasone** as primary therapy for a member who is eligible for ASCT? Yes☐ No☐

E. Will daratumumab be used in combination with **bortezomib, lenalidomide, and dexamethasone** as primary therapy for a member who is eligible for ASCT? Yes☐ No☐

F. Will daratumumab be used after at least 1 prior therapy in combination with 1 of the following therapy combinations listed below? Yes☐ No☐ If yes, please indicate which therapy combination will be used:

- ☐ dexamethasone and bortezomib
- ☐ carfilzomib and dexamethasone
- ☐ dexamethasone and lenalidomide
- ☐ cyclophosphamide, bortezomib, and dexamethasone
- ☐ pomalidomide and dexamethasone*

  *For this combination, does previous therapy include lenalidomide and a proteasome inhibitor (PI)? Yes☐ No☐

- ☐ Other: _____

G. Will daratumumab be used in combination with **lenalidomide and dexamethasone** for members who are ineligible for ASCT? Yes☐ No☐

H. Will daratumumab be used in combination with **cyclophosphamide, bortezomib, and dexamethasone** as primary therapy? Yes☐ No☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.
All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.

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Member Name:_____ Date of Birth:_____ Member ID#:_____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, Continued:

1. Please indicate the diagnosis and information, continued:

☐ **Multiple Myeloma**

I. Will daratumumab be used for disease relapse after 6 months following primary induction therapy with the same regimen? Yes☐ No☐

J. Will daratumumab be used as a single-agent after ≥3 prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent, or double refractory to a PI and an immunomodulatory agent? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on daratumumab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to daratumumab therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Additional Information:_____

_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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