aetna®

MEDICARE FORM

Darzalex™ (daratumumab) Medication Precertification Request

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

For Ohio MMP:
FAX: 1-855-734-9389
PHONE: 1-855-364-0974

For other lines of business:
Please use other form

Note: Darzalex 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

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 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 (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):

Note: Darzalex is non-preferred. The preferred products are Bortezomib and Velcade.

☐ Yes ☐ No Has the patient had prior therapy with Darzalex within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Velcade ☐ Bortezomib

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Velcade ☐ Bortezomib

_____

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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.

☐ **Multiple myeloma**

What is the prescribed regimen?

☐ Darzalex 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?

☐ Darzalex in combination with bortezomib and dexamethasone
- → ☐ Yes ☐ No Has the patient received at least one prior therapy?

☐ Darzalex 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?

☐ Darzalex 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?

☐ Darzalex 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?

☐ Darzalex in combination with carfilzomib and dexamethasone
- → ☐ Yes ☐ No Is the patient's disease relapsed or progressive?

☐ Darzalex in combination with cyclophosphamide, bortezomib and dexamethasone

☐ Darzalex 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?

☐ Darzalex 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 PI and an immunomodulatory agent?

☐ Other regimen (please explain): _____

☐ **Systemic light chain amyloidosis**

☐ Yes ☐ No Is the patient's disease relapsed or refractory?

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.