



MEDICARE FORM

Darzalex™ (daratumumab) Medication Precertification Request

Page 1 of 2

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

For New Jersey HMO D-SNP:

FAX: 1-833-322-0034

PHONE: 1-844-362-0934

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name:	(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
UPIN:	Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____				

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____
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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
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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?

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?

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.