

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

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

For Initial Authorization:

1. Please indicate the diagnosis and information

Multiple Myeloma - please indicate in which setting the requested medication will be used:

Primary therapy in members who are ineligible for autologous stem cell transpslant in combination with:

- Lenalidomide and dexamethasone
- Bortezomib, melphalan and prednisone
- Bortezomib, lenalidomide and dexamethasone

Primary therapy in members who are eligible for autologous stem cell transplant in combination with:

- Bortezomib and thalidomide or lenalidomide and dexamethasone
- Carfilzomib, lenalidomide and dexamethasone

Maintenance therapy for response or stable disease following hematopoietic stem cell transplant (HCT) or primary myeloma therapy and:

- Used as a single agent
- Used in combination with lenalidomide

After at least 1 prior therapy, in combination with:

- Bortezomib and dexamethasone
- Carfilzomib and dexamethasone
- Lenalidomide and dexamethasone
- Pomalidomide and dexamethasone*

*For this combination, does previous therapy include lenalidomide and a proteasome inhibitor?

Yes ___ No ___

- Cyclophosphamide, bortezomib and dexamethasone
- Selinexor and dexamethasone
- Venetoclax and dexamethasone for patients with t(11:14) translocation

(Page 1 of 2 - diagnosis continued on page 2)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

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

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

Multiple Myeloma (*continued*)

For disease relapse after 6 months following primary induction therapy with the same regimen and used in combination with:

Lenalidomide and dexamethasone

Cyclophosphamide, bortezomib and dexamethasone

As a single agent in members who have received ≥ 3 prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent, or who are double refractory to a PI and an immunomodulatory agent

For relapsed or refractory disease in combination with teclistamab-cqyv after at least 1 prior line of therapy including a proteasome inhibitor and an immunomodulatory agent

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 venetoclax for t(11;14) translocation in relapsed or refractory disease? Yes ____ No ____

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

Smoldering Myeloma

A. Is diagnosis high-risk smoldering myeloma (asymptomatic)? Yes ____ No ____

B. Will daratumumab be used as a single agent? Yes ____ No ____

Other: _____

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: _____

(Page 2 of 2)

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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