OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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

☐ **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☐

☐ **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

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

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

DRAFT

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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)*

☐ 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
- ☐ Iberdomide and dexamethasone

☐ 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 theapy including a proteasome inhibitor and an immunomodulatory agent

☐ **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: _____

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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