JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Darzalex Faspro

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Multiple myeloma, *Continue to #2*

❒ Light chain amyloidosis, *Continue to #3*

❒ Other, *No Further Questions*

2. Is the prescribed regimen the requested medication in combination with bortezomib, thalidomide, and dexamethasone?

❒ Yes, *Continue to #30*

❒ No, *Continue to #3*

3. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #4*

❒ No, *Continue to #8*

4. What is the diagnosis?

❒ Multiple myeloma, *Continue to #5*

❒ Light chain amyloidosis, *Continue to #6*

5. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. How many months has the patient received therapy with the requested medication? (Please use fill-in-the-blank format on fax form.)

❒ 12 months or less, *No Further Questions*

❒ 13 months, *No Further Questions*

❒ 14 months, *No Further Questions*

❒ 15 months, *No Further Questions*

❒ 16 months, *No Further Questions*

❒ 17 months, *No Further Questions*

❒ 18 months, *No Further Questions*

❒ 19 months, *No Further Questions*

❒ 20 months, *No Further Questions*

❒ 21 months, *No Further Questions*

❒ 22 months, *No Further Questions*
❒ 23 months, *No Further Questions*
❒ 24 months and greater, *No Further Questions*

8. What is the diagnosis?
❒ Multiple myeloma, *Continue to #9*
❒ Light chain amyloidosis, *Continue to #100*

9. What is the prescribed regimen?
❒ The requested medication in combination with pomalidomide and dexamethasone, *Continue to #10*
❒ The requested medication as a single agent, *Continue to #20*
❒ The requested medication in combination with bortezomib, lenalidomide, and dexamethasone, *Continue to #31*
❒ The requested medication in combination with carfilzomib, lenalidomide, and dexamethasone, *Continue to #31*
❒ The requested medication in combination with bortezomib, melphalan, and prednisone, *Continue to #40*
❒ The requested medication in combination with selinexor and dexamethasone, *Continue to #50*
❒ The requested medication in combination with bortezomib and dexamethasone, *Continue to #60*
❒ The requested medication in combination with carfilzomib and dexamethasone, *Continue to #60*
❒ The requested medication in combination with cyclophosphamide, bortezomib, and dexamethasone, *No Further Questions*
❒ The requested medication in combination with lenalidomide and dexamethasone, *Continue to #70*
❒ Other, *No Further Questions*

In combination with pomalidomide and dexamethasone

10. Has the patient received at least one prior regimen, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

As a single agent

20. Will the requested medication be used for maintenance therapy?
❒ Yes, *Continue to #80*
❒ No, *Continue to #21*

21. Has the patient received at least three prior regimens, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *Continue to #22*

22. Is the patient double refractory to a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

In combination with bortezomib, thalidomide and dexamethasone, in combination with bortezomib, lenalidomide, and dexamethasone or in combination with carfilzomib, lenalidomide, and dexamethasone

30. Will the requested medication be used for a maximum of 16 doses?

❒ Yes, *Continue to #31*

❒ No, *Continue to #31*

31. Is the patient eligible for transplant?

❒ Yes, *Continue to #32*

❒ No, *Continue to #32*

32. Will the requested medication be used as primary therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

In combination with bortezomib, melphalan, and prednisone

40. Is the patient eligible for transplant?

❒ Yes, *Continue to #41*

❒ No, *Continue to #41*

41. Will the requested medication be used as primary therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

In combination with selinexor and dexamethasone

50. Has the patient been previously treated for multiple myeloma?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

In combination with bortezomib and dexamethasone or in combination with carfilzomib and dexamethasone

60. Has the patient received at least one prior regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

In combination with lenalidomide and dexamethasone

70. Is the patient eligible for transplant?

❒ Yes, *Continue to #72*

❒ No, *Continue to #71*

71. Will the requested medication be used as primary therapy?

❒ Yes, *No Further Questions*

❒ No, *Continue to #72*

72. Has the patient received at least one prior regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Single-agent maintenance therapy

80. Is the requested medication being used to treat symptomatic multiple myeloma?

❒ Yes, *Continue to #81*

❒ No, *Continue to #81*

81. Is the patient a transplant candidate?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Light chain amyloidosis

100. Is the patient newly diagnosed with light chain amyloidosis?

❒ Yes, *Continue to #101*

❒ No, *Continue to #102*

101. Will the requested drug be used in combination with bortezomib, cyclophosphamide and dexamethasone?

❒ Yes, *No Further Questions*

❒ No, *Continue to #102*

102. Is the patient's disease relapsed or refractory?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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