Darzalex

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 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

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Multiple myeloma, *Continue to 2*

❒ Systemic light chain amyloidosis, *Continue to 3*

❒ Other, please specify. _____, *No Further Questions*

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

❒ Yes, *Continue to 11*

❒ No, *Continue to 3*

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

❒ Yes, *Continue to 4*

❒ No, *Continue to 5*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

5. What is the diagnosis?

❒ Multiple myeloma, *Continue to 6*

❒ Systemic light chain amyloidosis, *Continue to 23*

6. What is the prescribed regimen?

❒ The requested medication in combination with pomalidomide and dexamethasone, *Continue to 7*

❒ The requested medication as a single agent, *Continue to 8*

❒ The requested medication in combination with bortezomib, lenalidomide, and dexamethasone, *Continue to 12*

❒ The requested medication in combination with carfilzomib, lenalidomide, and dexamethasone, *Continue to 12*

❒ The requested medication in combination with bortezomib, melphalan, and prednisone, *Continue to 14*

❒ The requested medication in combination with selinexor and dexamethasone, *Continue to 16*

❒ The requested medication in combination with bortezomib and dexamethasone, *Continue to 17*

❒ The requested medication in combination with carfilzomib and dexamethasone, *Continue to 17*

❒ The requested medication in combination with cyclophosphamide, bortezomib, and dexamethasone, *No further Questions*

❒ The requested medication in combination with lenalidomide and dexamethasone, *Continue to 18*

❒ Other, please specify. _____, *No Further Questions*

7. 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*

8. Will the requested medication be used for maintenance therapy?
❒ Yes, *Continue to 21*
❒ No, *Continue to 9*

9. 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 10*

10. 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*

11. Will the requested medication be used for a maximum of 16 doses?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the patient eligible for transplant?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Will the requested medication be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Is the patient eligible for transplant?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Will the requested medication be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Has the patient been previously treated for multiple myeloma?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. Has the patient received at least one prior regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Is the patient eligible for transplant?
❒ Yes, *Continue to 20*
❒ No, *Continue to 19*

19. Will the requested medication be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *Continue to 20*

20. Has the patient received at least one prior regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Is the requested medication being used to treat symptomatic multiple myeloma?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Is the patient a transplant candidate?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. 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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