OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Darzalex® (Daratumumab) and Darzalex Faspro® (Daratumumab/Hyaluronidase-fihj)
Prior Authorization Form

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

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

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 bortezomib, cyclophosphamide, and dexamethasone for newly diagnosed disease? Yes☐ No☐

☐ **Multiple Myeloma**

A. Will daratumumab be used in combination with **lenalidomide and dexamethasone** as primary therapy for a member who is ineligible for autologous stem cell transplant (ASCT)? Yes☐ No☐

B. Will daratumumab be used in combination with **lenalidomide and dexamethasone** after at least 1 prior therapy? Yes☐ No☐

C. Will daratumumab be used in combination with **bortezomib, melphalan, and prednisone** as primary therapy for a member who is ineligible for ASCT? Yes☐ No☐

D. Will daratumumab be used in combination with **bortezomib, thalidomide, and dexamethasone** as primary therapy for a member who is eligible for ASCT? Yes☐ No☐

E. Will daratumumab be used in combination with **bortezomib, lenalidomide, and dexamethasone** as primary therapy for a member who is eligible for ASCT? Yes☐ No☐

F. Will daratumumab be used after at least 1 prior therapy in combination with 1 of the following therapy combinations listed below? Yes☐ No☐ If yes, please indicate which therapy combination will be used:

- ☐ dexamethasone and bortezomib
- ☐ carfilzomib and dexamethasone
- ☐ dexamethasone and lenalidomide
- ☐ cyclophosphamide, bortezomib, and dexamethasone
- ☐ pomalidomide and dexamethasone*

*For this combination, does previous therapy include lenalidomide and a proteasome inhibitor (PI)? Yes☐ No☐

- ☐ Other:_____

G. Will daratumumab be used in combination with **lenalidomide and dexamethasone** for members who are ineligible for ASCT? Yes☐ No☐

H. Will daratumumab be used in combination with **cyclophosphamide, bortezomib, and dexamethasone** as primary therapy? Yes☐ No☐

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

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Page 2 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.

For Initial Authorization, Continued:

1. Please indicate the diagnosis and information, continued:

☐ **Multiple Myeloma**

I. Will daratumumab be used for disease relapse after 6 months following primary induction therapy with the same regimen? Yes ☐ No ☐

J. Will daratumumab be used as a single-agent after ≥3 prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent, or double refractory to a PI and an immunomodulatory agent? Yes ☐ No ☐

☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

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: _____

Additional Information: _____

_____

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.*

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.*