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

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 carfilzomib and dexamethasone in relapsed or progressive disease? Yes ☐ No ☐
  - F. Will daratumumab be used in combination with bortezomib and dexamethasone after at least 1 prior therapy? Yes ☐ No ☐
  - G. Will daratumumab be used in combination with pomalidomide and dexamethasone after ≥2 prior therapies including a proteasome inhibitor (PI) and an immunomodulatory agent? Yes ☐ No ☐
  - H. Will daratumumab be used as a single-agent after ≥3 prior therapies, including a 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:** _____

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.*

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