Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Darzalex (daratumumab)
Darzalex Faspro (daratumumab; hyaluronidase-fihj)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Darzalex 100mg/5ml ☐ Darzalex 400mg/20mg ☐ Darzalex Faspro 1800mg/30,000 units

Dose: Frequency of therapy: Duration of therapy:

What is your patient's current weight? _____ lbs or kg (circle one) ICD10:

Is this a new start? Yes ☐ No ☐ Start Date: :
(if continued therapy) What week of therapy is your patient currently at?

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

(if Darzalex IV) What is the patient's diagnosis or reason for treatment?
☐ Amyloidosis
☐ Erdheim-Chester Disease
☐ Hepatobiliary cancers (including gallbladder, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)
☐ Multiple Myeloma
☐ Other (please specify):

(if Darzalex Faspro) What is the patient's diagnosis or reason for treatment?
☐ Amyloidosis
☐ multiple myeloma (MM)
☐ Other (please specify):

Clinical Information

(if multiple myeloma) Will the requested drug be used as single agent therapy? Yes ☐ No ☐

(if not single agent) Will the requested drug be used in combination with bortezomib (Velcade), melphalan, and prednisone (VMP)? Yes ☐ No ☐

(if in combo with VMP) When first starting the requested drug, is/was your patient newly diagnosed and NOT eligible for autologous stem cell transplant (auto-SCT)? Yes ☐ No ☐

(if not in combo with VMP) Will the requested drug be used in combination with Velcade AND dexamethasone ONLY? Yes ☐ No ☐

(if not in combo with Velcade and dexamethasone) Will the requested drug be using in combination with Revlimid AND dexamethasone? Yes ☐ No ☐

(if in combo with Revlimid or Velcade AND dexamethasone) Has your patient previously received any chemotherapy for this diagnosis? Yes ☐ No ☐

(if in combo with Revlimid AND dexamethsone, no previous chemo for this diagnosis) When first starting the requested drug, is/was your patient newly diagnosed and NOT eligible for autologous stem cell transplant (auto-SCT)? Yes ☐ No ☐

(if not in combo with VMP OR not with Revlimid or Velcade AND dexamethasone) Will the requested drug be used in combination with Pomalyst AND dexamethasone? Yes ☐ No ☐

(if in combo with Pomalyst and dexamethasone) Has your patient previously received at least 2 prior therapies for multiple myeloma? Yes ☐ No ☐

(if 2 prior therapies) Did your patient ever receive a proteasome inhibitor (PI) (such as Empliciti, Kyprolis, Ninlaro, Velcade) AND Revlimid? Yes ☐ No ☐

(if not in combo with VMP, Revlimid or Velcade or Pomalyst AND dexamethasone) Will the drug requested be used in combination with bortezomib (Velcade), thalidomide and dexamethasone (VTd)? Yes ☐ No ☐

(if with VTD) When first starting the requested drug, is/was your patient newly diagnosed and eligible for autologous stem cell transplant (auto-SCT)? Yes ☐ No ☐

(if no and Faspro) Will the requested drug be used in combination with Velcade (bortezomib), Revlimid (lenalidomide), AND dexamethasone? Yes ☐ No ☐

(if yes) When first starting the requested drug, is/was your patient newly diagnosed and eligible for autologous stem cell transplant (auto-SCT)? Yes ☐ No ☐

(if yes) Will the requested medication be used for induction and consolidation? Yes ☐ No ☐

(if not in combo with VTd and requesting IV Darzalex) Will the drug requested be used in combination with carfilzomib (Kyprolis) and dexamethasone? Yes ☐ No ☐

(if IV Darzalex with Kyprolis and dexamethasone) Has your patient received one to three prior lines of therapy? Yes ☐ No ☐

(if single agent) Was your patient refractory to BOTH a proteasome inhibitor (Velcade, Kyprolis, Ninlaro, Empliciti) AND an immunomodulatory agent (Revlimid, Pomalyst, Thalomid)? Yes ☐ No ☐

(if no) Has your patient previously received at least prior 3 therapies for multiple myeloma? Yes ☐ No ☐

(if yes) Did your patient ever receive a proteasome inhibitor (PI) (i.e. Empliciti, Kyprolis, Ninlaro, Velcade) AND an immunomodulatory agent (IMiD) (i.e. Pomalyst, Revlimid, Thalomid)?
☐ Yes, received one from each class of drugs
☐ No or Unknown

(if IV form and systemic light-chain amyloidosis) Does your patient have relapsed/refractory systemic light chain amyloidosis??

Yes ☐ No ☐

(if Faspro and amyloidosis) Prior to starting this medication, is/was your patient considered newly diagnosed? Yes ☐ No ☐

(if Faspro and amyloidosis) Is/Will the requested medication be(ing) used in combination with bortezomib (Velcade), cyclophosphamide and dexamethasone (D-VCd)? Yes ☐ No ☐

(if Darzalex and Hepatobiliary cancers) Will the requested medication be taken in combination with trametinib (Mekinist)? Yes ☐ No ☐

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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