



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

Darzalex (daratumumab)

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

Dose: Frequency of therapy: Duration of therapy:

ICD10:

Is this a new start? Yes No Start Date: :

Where will this medication be obtained?

- Accredo Specialty Pharmacy**
- Retail pharmacy
- Prescriber's office stock (billing on a medical claim form)
- Home Health / Home Infusion vendor
- Other (please specify):
- **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:

Clinical Information

If Multiple Myeloma:

(Will the requested drug be used as single agent therapy? Yes No

Will the requested medication be used in combination with any of the following?

- Velcade (bortezomib), melphalan, and prednisone [VMP]
- bortezomib AND dexamethasone
- carfilzomib AND dexamethasone
- lenalidomide AND dexamethasone
- pomalidomide AND dexamethasone
- bortezomib, thalidomide, and dexamethasone
- None of the above

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

(if in combo with bortezomib AND dexamethasone OR lenalidomide and dexamethasone) Has your patient previously received any chemotherapy for this diagnosis? Yes No

(if in combo with lenalidomide AND dexamethasone, 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 in combo with pomalidomide 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 AND lenalidomide? Yes No

(if in combo with bortezomib, thalidomide, and dexamethasone) When first starting the requested medication, is/was your patient newly diagnosed and eligible for autologous stem cell transplant (auto-SCT)? Yes No

(if single agent) Is the patient double-refractory to a proteasome inhibitor AND an immunomodulatory agent? 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) AND an immunomodulatory agent?

- Yes, received one from each class of drugs
- Received one from only one class
- None of the above

(if in combo with bortezomib AND dexamethasone) Will the requested medication be taken in combination with trametinib (Mekinist)? Yes No

(if in combo with carfilzomib AND dexamethasone) Has your patient received one to three prior lines of therapy? Yes No

If Amyloidosis:

Does your patient have relapsed/refractory systemic light chain amyloidosis? Yes No

Additional Pertinent Information:

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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