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:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City:	State:	Zip:
Office Street Address:			Patient Phone:		
City:	State:	Zip:			

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) Diagnosis related to use:
☐ multiple myeloma (MM) ☐ systemic light-chain amyloidosis
☐ Other (please specify):

(if Darzalex Faspro) Diagnosis related to use:
☐ 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 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) How many prior lines of therapy have been tried for this diagnosis?

☐ 1
☐ 2
☐ 3
☐ 4 or more
☐ none or unknown

(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 or refractory disease? 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 ☐

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:**______________________

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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.

v010124

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005