Darzalex Faspro

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst Darzalex Faspro SGM 3854-A – 06/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?
❒ Multiple myeloma, *Continue to 2*
❒ POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome, *Continue to 3*
❒ Systemic light chain amyloidosis, *Continue to 3*
❒ Other, please specify. _____, *No Further Questions*

2. What is the requested regimen?
❒ The requested drug in combination with bortezomib, thalidomide, and dexamethasone, *Continue to 13*
❒ The requested drug in combination with bortezomib, lenalidomide, and dexamethasone, *Continue to 13*
❒ None of the above, *Continue to 3*

3. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 8*

4. What is the diagnosis?
❒ Multiple myeloma, *Continue to 5*
❒ POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome, *Continue to 5*
❒ Systemic light chain amyloidosis, *Continue to 6*

5. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *Continue to 7*

7. How many months has the patient received therapy with the requested drug?
_____ months, *No Further Questions*

8. What is the diagnosis?
❒ Multiple myeloma, *Continue to 9*
❒ POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome, *Continue to 30*
❒ Systemic light chain amyloidosis, *Continue to 28*

9. What is the prescribed regimen?
❒ The requested drug in combination with pomalidomide and dexamethasone, *Continue to 10*
❒ The requested drug as a single agent, *Continue to 11*

❒ The requested drug in combination with carfilzomib, lenalidomide, and dexamethasone, *Continue to 14*
❒ The requested drug in combination with bortezomib, melphalan, and prednisone, *Continue to 16*
❒ The requested drug in combination with selinexor and dexamethasone, *Continue to 18*
❒ The requested drug in combination with venetoclax and dexamethasone, *Continue to 19*
❒ The requested drug in combination with bortezomib and dexamethasone, *Continue to 21*
❒ The requested drug in combination with carfilzomib and dexamethasone, *Continue to 21*
❒ The requested drug in combination with cyclophosphamide, bortezomib, and dexamethasone, *No Further Questions*
❒ The requested drug in combination with lenalidomide and dexamethasone, *Continue to 22*
❒ The requested drug in combination with lenalidomide, *Continue to 25*
❒ The requested drug in combination with carfilzomib, pomalidomide, and dexamethasone, *Continue to 18*
❒ Other, please specify. _____, *No Further Questions*

10. Has the patient received at least one prior regimen, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Has the patient received at least three prior regimens, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 12*

12. Is the patient double refractory to a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Will the requested drug be used for a maximum of 16 doses?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the patient eligible for transplant?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Will the requested drug be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Is the patient eligible for transplant?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the requested drug be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Has the patient been previously treated for multiple myeloma?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Does the patient have a documented t(11:14) translocation? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of t(11:14) translocation.
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*
❒ Unknown, *Continue to 20*

20. Has the patient been previously treated for multiple myeloma?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Has the patient received at least one prior regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Is the patient eligible for transplant?
❒ Yes, *Continue to 24*
❒ No, *Continue to 23*

23. Will the requested drug be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *Continue to 24*

24. Has the patient received at least one prior regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Will the requested drug be used for maintenance therapy?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is the patient a transplant candidate?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Is the requested drug being used to treat symptomatic multiple myeloma?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

28. What is the requested regimen?
❒ The requested drug in combination with bortezomib, cyclophosphamide and dexamethasone, *No Further Questions*
❒ As a single agent, *No Further Questions*
❒ The requested drug in combination with lenalidomide and dexamethasone, *Continue to 29*
❒ Other, please specify. _____, *Continue to 29*

29. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *No Further Questions*
❒ Refractory disease, *No Further Questions*
❒ Other, please specify. _____, *No Further Questions*

30. Will the requested drug be used in combination with lenalidomide and dexamethasone?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. What the requested drug be used as induction therapy?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Is the patient a transplant candidate?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720