BlueCross BlueShield Federal Employee Program

DARZALEX
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Darzalex (daratumumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   ❑Multiple Myeloma (MM)
   ❑Other diagnosis ***(please specify):*** _____

2. Has the patient been on Darzalex continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Is the multiple myeloma newly diagnosed? ***Please select answer below:***

❑**Yes**: Is the patient eligible for autologous stem cell transplant? ***Please select answer below:***

❑**Yes**: Will Darzalex be used in combination with bortezomib (Velcade), thalidomide, and dexamethasone? ❑Yes ❑No

❑**No**: Will Darzalex be used in combination with bortezomib (Velcade), melphalan, and prednisone ? ❑Yes ❑No*

****If NO***, will Darzalex be used in combination with lenalidomide (Revlimid) and dexamethasone? ❑Yes ❑No

❑**No**: Please answer the following questions:

i. Will Darzalex be used as monotherapy? ❑Yes* ❑No

If YES, has the patient received at least three prior lines of therapy, including a proteasome inhibitor (PI) and immunomodulatory agent? ❑Yes ❑No*

****If NO***, has the patient had a double-refractory failure to a proteasome inhibitor (PI) and an immunomodulatory agent? ❑Yes ❑No

ii. Will Darzalex be used in combination with carfilzomib (Kyprolis) and dexamethasone? ❑Yes* ❑No

If YES, please answer the following questions:

1) Does the patient have relapsed or refractory multiple myeloma? ❑Yes ❑No

2) Has the patient received one to three prior lines of therapy to treat multiple myeloma? ❑Yes ❑No

iii. Will Darzalex be used in combination with lenalidomide (Revlimid) and dexamethasone? ❑Yes* ❑No

If YES, please answer the following questions:

1) Does the patient have relapsed or refractory multiple myeloma? ❑Yes ❑No

2) Has the patient received at least one prior therapy to treat multiple myeloma? ❑Yes ❑No

iv. Will Darzalex be used in combination with bortezomib (Velcade) and dexamethasone? ❑Yes* ❑No

If YES, has the patient received at least one prior therapy to treat multiple myeloma? ❑Yes ❑No

v. Will Darzalex be used in combination with pomalidomide (Pomalyst) and dexamethasone? ❑Yes* ❑No

If YES, has the patient received at least two prior therapies to treat multiple myeloma, including lenalidomide (Revlimid) and a proteasome inhibitor (PI)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient experienced disease progression or unacceptable toxicity while on Darzalex therapy? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***