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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Darzalex[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)	Provider Information (required)
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Multiple myeloma

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Darzalex therapy? Yes No

Has the patient used Darzalex within the past 120 days? Yes No

Is Darzalex prescribed by or in consultation with an oncologist/hematologist? Yes No

Select if the patient has had previous treatment with the following regimens:

Protease inhibitor [e.g., bortezomib (Velcade), carfilzomib (Kyprolis)]

Immunomodulatory agent [e.g., lenalidomide (Revlimid), thalidomide (Thalomid)]

Other: _____

Is the patient double-refractory to a proteasome inhibitor and an immunomodulatory agent? Yes No

Select if Darzalex will be used in combination with the following treatment regimens:

Lenalidomide and dexamethasone

Bortezomib and dexamethasone

Pomalidomide and dexamethasone

Does the patient have newly diagnosed multiple myeloma? Yes No

Is the patient ineligible for autologous stem cell transplant? Yes No

Select if Darzalex will be used in combination with the following:

Bortezomib

Melphalan

Prednisone

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Darzalex_CMS_2019Jan-W