OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
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)		
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:
❑ Check if requesting **brand**	Directions for Use:	
❑ 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 immunomodulary 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.