[Insert Physician Letterhead]

[Insert Name of Medical Director]
[Insert Payer Name]
[Insert Address]
[Insert City, State Zip]

RE: Member Name: [Insert Member Name]
Member Number: [Insert Member Number]
Group Number: [Insert Group Number]

**REQUEST:** Authorization for treatment with DARZALEX™ (daratumumab)
**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]
**DOSE AND FREQUENCY:** [Insert Dose & Frequency]
**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director]:

I am writing to request a **formulary exception** for the above-mentioned patient to receive intravenous treatment with DARZALEX™, [indication]. This request is consistent with the indication statement for DARZALEX™. My request is supported by the following:

**Summary of Patient's Diagnosis**
[Insert patient's diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient History**
[Insert previous therapies/procedures, response to those interventions, description of patient's recent symptoms/condition. Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

**Rationale for Treatment**
Considering the patient's history, condition, and the full Prescribing Information supporting uses of DARZALEX™, I believe treatment with DARZALEX™ at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service. The accompanying full Prescribing Information provides the approved clinical information for DARZALEX™.

Given the urgent nature of this request, please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,
[Insert Physician Name and Participating Provider Number]

P.S. – ☐ If this request is denied, I am requesting an expedited Exception reviewed by a "Like" specialist.