

[Insert Physician Letterhead]

[Insert Name of Medical Director] RE: Member Name: [Insert Member Name]
[Insert Payer Name] Member Number: [Insert Member Number]
[Insert Address] Group Number: [Insert Group Number]
[Insert City, State Zip]

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 support my request for an **authorization** for the above-mentioned patient to receive intravenous treatment with DARZALEX™, [insert 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.