

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
 Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

March 31, 2026

DARATUMUMAB HYALURONIDASE (DARZALEX FASPRO) UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Daratumumab hyaluronidase (Darzalex Faspro) is on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective June 1, 2026**, the criteria for Darzalex Faspro will be updated to include a quantity limit for patients with light chain amyloidosis. **This letter is a notification of the upcoming change in coverage for this medication under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. (Kaiser Permanente) require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician’s office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee’s evidence-based criteria for coverage.

Prior Authorization Criteria for Daratumumab hyaluronidase (Darzalex Faspro) (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
Daratumumab hyaluronidase (Darzalex Faspro)	<p>Covered for patients with Multiple Myeloma if all the following apply:</p> <ul style="list-style-type: none"> • Given once monthly therapy. • After completion of titration with a CD38 IV drug. <p>Not covered for first-line maintenance in patients eligible for transplant</p> <p>Covered for patients with light chain amyloidosis OR multiple myeloma associated with amyloidosis</p> <p>Quantity limit:</p> <ul style="list-style-type: none"> • Multiple Myeloma: <ul style="list-style-type: none"> ○ Maximum dose: 1,800 mg/30,000 units (1,800 mg daratumumab and 30,000 units hyaluronidase) per dose, once every 28 days. • Light Chain Amyloidosis: <ul style="list-style-type: none"> ○ After 16 doses (25 weeks), maximum dose: 1,800 mg/30,000 units (1,800 mg daratumumab and 30,000 units hyaluronidase) per dose, once every 28 days, for a maximum of 2 years. • No QL for Multiple Myeloma associated with Amyloidosis <p>Initial authorization: 2 months</p> <p>Reauthorization is required every 6 months to confirm the disease has not progressed</p>

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at <https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject>.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Ubriani".

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee