Payers may require prior authorization or supporting documentation to process and cover a claim for treatment with BLENREP (belantamab mafodotin-blmf). A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific letter of medical necessity will help to explain the physician's clinical decision-making and rationale for choosing BLENREP. The following is a sample letter of medical necessity for BLENREP that should be customized based on your patient's medical history and demographic information. Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity. Use of this letter of medical necessity does not guarantee that the payer will approve your request.

SAMPLE LETTER OF MEDICAL NECESSITY

[Date]

[Contact Name of medical director or other Payer representative] [Contact Title]

[Name of Health Insurance Company] [Street Address, City, State, Zip]

Re: Letter of Medical Necessity for [HCPCS Code] [BLENREP, billing unit]

Patient: [Patient Name] Group/Policy Number: [Number]

Date(s) of Service: [Dates]

Diagnosis: [C90.0 Multiple myeloma having not achieved remission or C90.02 Multiple myeloma in relapse]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [PATIENT NAME], to [REQUEST PRIOR AUTHORIZATION/DOCUMENT MEDICAL NECESSITY] for treatment with BLENREP (belantamab mafodotin-blmf). The patient will be treated with BLENREP for [C90.0 Multiple myeloma having not achieved remission or C90.02 Multiple myeloma in relapse].

This letter serves to document that [PATIENT NAME] needs BLENREP and that BLENREP is medically necessary for the patient as administered. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatments.

BLENREP is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma in combination with bortezomib and dexamethasone in patients who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

Medical History and Diagnosis
[In the letter of medical necessity, you need to provide a description of the patient's medical history, which may include:

- Information about clinical, imaging, and laboratory findings including bone marrow biopsy confirming diagnosis
- Detailed history of relapse(s)
- Previous treatment(s) and dosage, frequency, duration, including dates, and patient response to intervention
- Signs and symptoms to help describe the patient's current clinical presentation
- Clinical opinion of patient prognosis or disease progression]

[PATIENT NAME] is a [AGE] year-old patient diagnosed with [C90.0 Multiple myeloma having not achieved remission or C90.02 Multiple myeloma in relapse]. [PATIENT NAME] has been in my care since [DATE]. As a result of [C90.0 Multiple myeloma having not achieved remission or C90.02 Multiple myeloma in relapse] and [bone marrow biopsy results and other indicators of plasma cell disorder], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY]. Additionally, [PATIENT] has tried [immunomodulatory agent(s) (such as thalidomide, lenalidomide, or pomalidomide), proteasome inhibitor(s) (such as bortezomib, carfilzomib, or ixazomib), or anti-CD38 monoclonal antibody(ies) (such as daratumumab or isatuximab)] and [OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatment with BLENREP.

Based on the above facts, I am confident that you will agree that BLENREP is indicated and medically necessary for this patient. The plan of treatment is to start the patient on BLENREP. Administration of BLENREP is planned on [DATE] and will be continued approximately every [FREQUENCY].

Please consider coverage of BLENREP on [PATIENT NAME]'s behalf and approve use and subsequent payment for BLENREP as planned. Please refer to the enclosed Prescribing Information for BLENREP. If you have any further questions regarding this matter, please do not hesitate to call me at [PHYSICIAN TELEPHONE NUMBER].

Thank you for your prompt attention to this matter.

Sincerely,

[PHYSICIAN NAME], <DEGREE INITIALS>, [PROVIDER IDENTIFICATION NUMBER]

Enclosures:
[attach as appropriate: FDA approval letter (available at http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm) Prescribing Information (PI), clinic notes & labs, NCCN Guidelines]
CC: [Medical Director, patient, specialty society, Insurance Commissioner]