Payers may require prior authorization or supporting documentation in order 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 rationale and clinical decision-making in 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.*

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] [Drug name, billing unit]

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

Date(s) of Service: [Dates] Diagnosis: [Code & Description]

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 [DIAGNOSIS].

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

BLENREP is indicated for:

- Monotherapy treatment for adult patients with relapsed or refractory multiple myeloma who have received at least four prior therapies including an anti-CD38 monoclonal antibody, a proteasome inhibitor, and an immunomodulatory agent.

Medical History and Diagnosis

[PATIENT NAME] is a [AGE]-year-old [MALE/FEMALE] diagnosed with [DIAGNOSIS]. [PATIENT NAME] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY]. Additionally, [PATIENT] has tried [PREVIOUS THERAPIES] and [OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatments 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
CC: [Medical Director, patient, specialty society, Insurance Commissioner]