Payers may deny coverage of claims for treatment with BLENREP (belantamab mafodotin-blmf). A patient-specific letter of appeal and supporting documentation will help to explain the physician's rationale and clinical decision-making in treating with BLENREP. The following is a sample letter of appeal 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 appeal a denied claim and to document medical necessity.*

# SAMPLE LETTER OF APPEAL

[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/Appeal Letter 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 have recently received a [DENIAL FOR PAYMENT] for a claim for BLENREP (belantamab mafodotin-blmf). You have indicated that BLENREP is not covered by [INSURANCE PLAN NAME] because [REASON FOR DENIAL]. This letter serves as a request for reconsideration of a claim for charges of BLENREP administered by intravenous infusion to [PATIENT NAME] on [DATE(S) OF SERVICE].

[PATIENT NAME] has been under my treatment for diagnosis of [DIAGNOSIS INFORMATION] since [DATE]. Due to the patient's clinical condition, the plan of treatment was to start the patient on BLENREP. BLENREP was initially administered on [DATE OF TREATMENT] and continued approximately every [FREQUENCY]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatment with BLENREP.

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.

Because of [INSERT RELEVANT PATIENT INFORMATION SUCH AS HISTORY, DIAGNOSIS], I have administered BLENREP as a medically necessary part of this patient's treatment, and we would appreciate your reconsideration of the [DATE(S) OF SERVICE] claim for [PATIENT NAME]. Please contact me at [PHYSICIAN PHONE NUMBER] if you require additional information or have any further questions.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician's Name], [Degree Initials] [Physician's practice name]

Enclosures:

[Original Claim Form]

[Denial/Explanation of Benefits]

[Additional Supporting Documents]