

Blenrep (belantamab mafodotin-blmf) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Drug Information** **Physician billing (HCPCS code:** _____ **)** **Pharmacy billing (NDC:** _____ **)****Dose:** _____ **Regimen:** _____ **Start Date (or date of next dose):** _____**Billing Provider Information****Provider NPI:** _____ **Provider Name:** _____**Provider Phone:** _____ **Provider Fax:** _____**Prescriber Information****Prescriber NPI:** _____ **Prescriber Name:** _____**Prescriber Phone:** _____ **Prescriber Fax:** _____ **Specialty:** _____**Criteria****For Initial Authorization:**

1. Please indicate the diagnosis and information:

 Relapsed or Refractory Multiple Myeloma

a. Will Blenrep be used in combination with bortezomib and dexamethasone? Yes ___ No ___

b. Has the member received 2 or more prior therapies? Yes ___ No ___

i. If yes, please indicate which of the following therapies member has received:

 Proteasome inhibitor Immunomodulatory agent Other: _____

c. Will member receive eye exams, including visual acuity and slit lamp ophthalmic examinations, at baseline, prior to each dose and promptly for any new or worsening symptoms?

Yes ___ No ___

d. Will prescriber comply with the risk evaluation and mitigation strategy (REMS) requirements?

Yes ___ No ___

 Other: _____**Additional Information:** _____**For Continued Authorization:**

1. Date of last dose: _____

2. Does patient have any evidence of progressive disease while on Blenrep therapy? Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to Blenrep therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____**Prescriber Signature:** _____ **Date:** _____***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.*****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE***This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*