



**State of Oklahoma
SoonerCare
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:

Multiple Myeloma

A. Does the member have a diagnosis of relapsed or refractory multiple myeloma?

Yes ___ No ___

B. Has the member received 4 or more prior therapies? Yes ___ No ___

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

Anti-CD38 monoclonal antibody

Proteasome inhibitor

Immunomodulatory agent

Other: _____

C. Will member receive eye exams, including visual acuity and slit lamp ophthalmic examinations, with each treatment cycle (every 3 weeks)? Yes ___ No ___

If answer is none of the above, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on belantamab mafodotin-blmf?

Yes ___ No ___

3. Has the member experienced adverse drug reactions related to belantamab mafodotin-blmf 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.

Please do not send in chart notes. Specific information will be requested if necessary. 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 Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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