State of Oklahoma SoonerCare Blenrep (Belantamab Mafodotin-blmf) Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

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: ____

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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: ____

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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.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	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.*