Blenrep (belantamab mafodotin-blmf)
(Intravenous)

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I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 6 months.
- Renewal: Prior authorization validity may be renewed every 6 months thereafter.

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

- 2,800 billable units every 21 days

III. Initial Approval Criteria [1]

Prior authorization validity is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Universal Criteria [1,4,5]

- Patient has an ophthalmic exam (including slit lamp exam and BCVA assessment) at baseline, prior to each dose, for new or worsening symptoms, and as clinically indicated; **AND**
- Therapy will be used in combination with preservative-free artificial tears; **AND**
- Patient does not have existing corneal epithelial disease *(Note: excludes mild punctate keratopathy)*; **AND**
- Patient has not had a prior allogeneic stem cell transplant; **AND**

Multiple Myeloma † ‡ Φ [1-5]

- Patient has relapsed or refractory disease; **AND**
  - Used in combination with bortezomib and dexamethasone †; **AND**
    - Patient has received at least two (2) prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent; **OR**
  - Used as a single agent ‡; **AND**
    - Patient has received at least three (3) prior lines of therapy

† FDA Approved Indication(s); ‡ Compendia Approved Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1]

Prior authorization validity may be renewed based upon the following criteria:

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- Patient continues to meet the indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: ocular toxicity, severe infusion-related reactions, thrombocytopenia, etc.

V. Dosage/Administration [1,6]

Indication	Dose
Multiple Myeloma	Administer 2.5 mg/kg (actual body weight) intravenously every 3 weeks until disease progression or unacceptable toxicity.

VI. Billing Code/Availability Information

HCPCS Code(s):

- J9053 – Injection, belantamab mafodotin-blmf, 0.1 mg; 1 billable unit = 0.1 mg *(Effective 07/01/2026)*
- C9399 – Unclassified drugs or biologicals *(Discontinue use on 07/01/2026)*
- J9999 – Not otherwise classified, antineoplastic drugs *(Discontinue use on 07/01/2026)*

NDC(s):

- Blenrep 70 mg lyophilized powder in single-dose vial for injection: 00173-0913-xx

VII. References

1. Blenrep [package insert]. Philadelphia, PA; GlaxoSmithKline LLC; October 2025. Accessed November 2025.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for belantamab mafodotin. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed November 2025.
3. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Multiple Myeloma Version 3.2026. National Comprehensive Cancer Network, 2022. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc."

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To view the most recent and complete version of the Guidelines, go online to NCCN.org. Accessed November 2025.

4. Hungria V, Robak P, Hus M, et al; DREAMM-7 Investigators. Belantamab Mafodotin, Bortezomib, and Dexamethasone for Multiple Myeloma. N Engl J Med. 2024 Aug 1;391(5):393-407. doi: 10.1056/NEJMoa2405090. Epub 2024 Jun 1. PMID: 38828933.
5. Hungria V, Robak P, Hus M, et al; DREAMM-7 study investigators. Belantamab mafodotin plus bortezomib and dexamethasone in patients with relapsed or refractory multiple myeloma (DREAMM-7): updated overall survival analysis from a global, randomised, open-label, phase 3 trial. Lancet Oncol. 2025 Aug;26(8):1067-1080. doi: 10.1016/S1470-2045(25)00330-4. Epub 2025 Jul 15. Erratum in: Lancet Oncol. 2025 Oct;26(10):e522. doi: 10.1016/S1470-2045(25)00488-7. PMID: 40680754.
6. Lonial S, Lee HC, Badros A, et al. Belantamab mafodotin for relapsed or refractory multiple myeloma (DREAMM-2): a two-arm, randomised, open-label, phase 2 study. Lancet Oncol. 2020 Feb;21(2):207-221. doi: 10.1016/S1470-2045(19)30788-0. Epub 2019 Dec 16. PMID: 31859245.

Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime's assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	Yes: Consider for PA
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C90.00	Multiple myeloma not having achieved remission
C90.02	Multiple myeloma in relapse
C90.10	Plasma cell leukemia not having achieved remission
C90.12	Plasma cell leukemia in relapse

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ICD-10	ICD-10 Description
C90.20	Extramedullary plasmacytoma not having achieved remission
C90.22	Extramedullary plasmacytoma in relapse
C90.30	Solitary plasmacytoma not having achieved remission
C90.32	Solitary plasmacytoma in relapse
Z85.79	Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

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