

DRUG POLICY

Blenrep® (belantamab mafodotin-blmf)

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Blenrep is indicated, in combination with bortezomib and dexamethasone, for the treatment of adults with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

Compendial Uses

1. Relapsed or refractory multiple myeloma
2. Polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes (POEMS) syndrome
3. Plasma-cell related monoclonal immunoglobulin deposition disease (MIDD)
4. Plasma cell-related monoclonal gammopathy of renal significance (MGRS)

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review: chart notes or medical record documentation demonstrating failure of previous lines of therapy.

Criteria for Initial Approval

Multiple Myeloma

Authorization of 12 months may be granted for the treatment of relapsed or refractory multiple myeloma in the following settings:

1. In combination with bortezomib and dexamethasone, when the member has received at least two lines of prior therapy, including a proteasome inhibitor and an immunomodulatory agent
2. As a single agent for maintenance therapy after completing 8 cycles of combination treatment with bortezomib and dexamethasone, when the member has received at least two lines of prior therapy including a proteasome inhibitor and an immunomodulatory agent
3. As a single agent, when the member has received at least three lines of prior therapy

POEMS, MIDD and MGRS

Authorization of 12 months may be granted, as a single agent or in combination with bortezomib and dexamethasone, for the treatment of POEMS syndrome, plasma cell-related MIDD, or plasma cell-related MGRS.

Continuation of Therapy

Authorization of 12 months (including new members) may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of disease progression or unacceptable toxicity while on the current regimen.

Other

Blenrep (belantamab mafodotin-blmf) is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J9053 - Injection, belantamab mafodotin-blmf, 0.1 mg (effective date 7/1/26)
- J9999 - Not otherwise classified, antineoplastic agents
- J3590 - Unclassified biologics
- C9399 - Unclassified drugs or biologics (for hospital outpatient department claims only)

REFERENCES

1. Blenrep [package insert]. Durham, NC: GlaxoSmithKline LLC.; October 2025.
2. The NCCN Drugs & Biologics Compendium® ©2025 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed November 4, 2025.
3. NCCN Clinical Practice Guidelines in Oncology Multiple Myeloma (Version 3.2026) 2025 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. November 4, 2025.

POLICY HISTORY

Policy #: 05.06.14

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