Cigna ®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Blenrep
(belantamab mafodotin-blmf)

PHYSICIAN INFORMATION	PATIENT INFORMATION
* Physician Name:	*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*
Specialty: * DEA, NPI or TIN:	
Office Contact Person:	* Patient Name:
Office Phone:	* Cigna ID: * Date of Birth:
Office Fax:	* Patient Street Address:
Office Street Address:	City: State: Zip:
City: State: Zip:	Patient Phone:

Urgency:
☐ Standard   ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Blenrep 100mg vial   ☐ Other (please specify):   ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form)   ☐ Hospital Outpatient
☐ Other (please specify):   ☐ Home Health / Home Infusion vendor

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient?   ☐ Yes ☐ No

Diagnosis related to use?
☐ multiple myeloma (MM)   ☐ other (please specify):

Clinical Information
(if MM) Does your patient have relapsed or refractory disease?   Yes ☐ No ☐
(if MM) Has your patient previously received at least 4 prior therapies for multiple myeloma?   Yes ☐ No ☐
     (if yes) Did your patient ever receive an anti-CD38 monoclonal antibody (such as Darzalex, Darzalex Faspro, or Sarclisa)?   Yes ☐ No ☐
     (if yes) Did your patient ever receive a proteasome inhibitor (PI) (such as Empliciti, Kyprolis, Ninlaro, Velcade)?   Yes ☐ No ☐
     (if yes) Did your patient ever receive an immunomodulatory agent (IMiD) (such as Pomalyst, Revlimid, Thalomid)?   Yes ☐ No ☐

Additional pertinent information *(please include disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)*:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or

insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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