STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

LENALIDOMIDE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
LENALIDOMIDE	REVLIMID, LENALIDOMIDE	33412		GPI-10 (9939405000)	

GUIDELINES FOR USE

1. Is the patient 18 years of age or older?

   If yes, continue to #2.
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

2. Does the patient have a diagnosis of multiple myeloma (MM)?

   If yes, continue to #3.
   If no, continue to #5.

3. Will Revlimid (lenalidomide) be used as induction treatment for multiple myeloma (MM)?

   If yes, **approve for 12 months by HICL or GPI-10 for #21 every 28 days.**
   If no, continue to #4.

4. Will Revlimid (lenalidomide) be used as maintenance treatment for multiple myeloma (MM)?

   If yes, **approve for 12 months by HICL or GPI-10 for #1 per day.**
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

5. Does the patient have a diagnosis of anemia due to a myelodysplastic syndrome (MDS) **AND** meet the following criterion?
   - The patient's myelodysplastic syndrome (MDS) is associated with a deletion 5q abnormality

   If yes, **approve for 12 months by HICL or GPI-10 for #1 per day.**
   If no, continue to #6.

6. Does the patient have a diagnosis of mantle cell lymphoma (MCL) **AND** meet the following criterion?
   - The patient has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib)

   If yes, **approve for 12 months by HICL or GPI-10 for #21 per 28 days.**
   If no, continue to #7.

CONTINUED ON NEXT PAGE

LENALIDOMIDE

GUIDELINES FOR USE (CONTINUED)

7. Does the patient have a diagnosis of follicular lymphoma (FL) and meet **ALL** of the following criteria?
   - The patient has previously been treated for follicular lymphoma (FL)
   - The requested medication is being taken in combination with a rituximab product

   If yes, **approve for 12 months by HICL or GPI-10 for #21 per 28 days for 12 fills.**
   If no, continue to #8.

8. Does the patient have a diagnosis of marginal zone lymphoma (MZL) and meet **ALL** the following criterion?
   - The patient has previously been treated for marginal zone lymphoma (MZL)
   - The requested medication is being taken in combination with a rituximab product

   If yes, **approve for 12 months by HICL or GPI-10 for #21 per 28 days for 12 fills.**
   If no, do not approve.

   DENIAL TEXT: Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **LENALIDOMIDE (Revlimid)** requires the following rule(s) be met for approval:
   A. You have ONE of the following diagnoses:
      1. Multiple myeloma (a type of blood cancer)
      2. Anemia due to a myelodysplastic syndrome (a type of blood cancer)
      3. Mantle cell lymphoma (a type of blood cell)
      4. Follicular lymphoma (a type of blood cancer)
      5. Marginal zone lymphoma (a type of blood cancer)
   B. You are 18 years of age or older
   C. **If you have anemia due to a myelodysplastic syndrome, approval also requires:**
      1. You have a deletion 5q (type of gene) abnormality
   D. **If you have mantle cell lymphoma, approval also requires:**
      1. You have relapsed or progressed (disease has returned or worsened) after two prior therapies, one of which included Velcade (bortezomib) (Note: Velcade may be covered under the medical benefit and/or require prior authorization).
   E. **If you have follicular lymphoma, approval also requires:**
      1. You have previously been treated for follicular lymphoma
      2. The requested medication is being taken in combination with a rituximab product (type of cancer drug)

   (Denial text continued on next page)

CONTINUED ON NEXT PAGE

LENALIDOMIDE

GUIDELINES FOR USE (CONTINUED)

F. **If you have marginal zone lymphoma, approval also requires:**
   1. You have previously been treated for marginal zone lymphoma
   2. The requested medication is being taken in combination with a rituximab product

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Revlimid.

REFERENCES

- Revlimid [Prescribing Information]. Summit, NJ: Celgene Corporation; August 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 04/01/22
Created: 08/12
Client Approval: 03/22
P&T Approval: 07/19