LENALIDOMIDE

Generic	Brand	HICL	GCN	Exception/Other
LENALIDOMIDE	REVLIMID	33412		

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 for #21 capsules 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 for #1 capsule 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 for #1 capsule per day.**
   If no, continue to #6.

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

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

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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 drug is being taken in combination with a rituximab product

   If yes, **approve for 12 months by HICL for #21 capsules 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 drug is being taken in combination with a rituximab product

   If yes, **approve for 12 months by HICL for #21 capsules per 28 days for 12 fills.**
   If no, do not approve.
   DENIAL TEXT: The guideline named **LENALIDOMIDE (Revlimid)** requires a diagnosis of multiple myeloma (MM), anemia due to a myelodysplastic syndrome (MDS), mantle cell lymphoma (MCL), follicular lymphoma (FL), or marginal zone lymphoma (MZL). The patient also must be 18 years of age or older. In addition, the following criteria must be met:
   For patients with myelodysplastic syndrome (MDS), approval requires:
   - The patient's MDS is associated with a deletion 5q abnormality

   For patients with mantle cell lymphoma (MCL), approval requires:
   - The patient has relapsed or progressed after at least two prior therapies, one of which included Velcade (bortezomib). Velcade may be covered under the medical benefit and/or require prior authorization.

   For patients with follicular lymphoma (FL), approval requires:
   - The patient has previously been treated for follicular lymphoma (FL)
   - The requested drug is being taken in combination with a rituximab product

   For patients with marginal zone lymphoma (MZL), approval requires:
   - The patient has previously been treated for marginal zone lymphoma (MZL)
   - The requested drug is being taken in combination with a rituximab product

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

REFERENCES
- Revlimid [Prescribing Information]. Summit, NJ: Celgene Corporation; May 2019.

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STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

LENALIDOMIDE

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/01/19

Created: 08/12
Client Approval: 08/19

P&T Approval: 07/19