

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Lenalidomide**

**INITIATION – Relapsed/refractory disease**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Patient has relapsed or refractory multiple myeloma with progressive disease

and

Patient has not previously been treated with lenalidomide

and

Lenalidomide to be used as third line\* treatment for multiple myeloma

or

Lenalidomide to be used as second line treatment for multiple myeloma

and

The patient has experienced severe (grade 3 or higher), dose limiting, peripheral neuropathy with either bortezomib or thalidomide that precludes further treatment with either of these treatments

and

Lenalidomide to be administered at a maximum dose of 25 mg/day in combination with dexamethasone

**CONTINUATION – Relapsed/refractory disease**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

No evidence of disease progression

and

The treatment remains appropriate and patient is benefitting from treatment

**INITIATION – Maintenance following first-line autologous stem cell transplant (SCT)**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Patient has newly diagnosed symptomatic multiple myeloma and has undergone first-line treatment that included an autologous stem cell transplantation

and

Patient has at least a stable disease response in the first 100 days after transplantation

and

Lenalidomide maintenance is to be commenced within 6 months of transplantation

and

Lenalidomide to be administered at a maximum dose of 15 mg/day

I confirm that the above details are correct:

Signed: ..... Date: .....

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**PRESCRIBER**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Lenalidomide** - *continued*

**CONTINUATION – Maintenance following first-line autologous stem cell transplant (SCT)**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

No evidence of disease progression

**and**

The treatment remains appropriate and patient is benefitting from treatment

Note: Indication marked with \* is an unapproved indication. A line of treatment is considered to comprise either: a) a known therapeutic chemotherapy regimen and supportive treatments or b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments. Prescriptions must be written by a registered prescriber in the lenalidomide risk management programme operated by the supplier.

I confirm that the above details are correct:

Signed: ..... Date: .....