

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 – Plasma cell dyscrasia**

**Prerequisites** (tick boxes where appropriate)

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

and

Patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

and

Patient is not refractory to prior lenalidomide use

**INITIATION – Myelodysplastic syndrome**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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

and

Patient has low or intermediate-1 risk myelodysplastic syndrome (based on IPSS or an IPSS-R score of less than 3.5) associated with a deletion 5q cytogenetic abnormality

and

Patient has transfusion-dependent anaemia

**CONTINUATION – Myelodysplastic syndrome**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

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

and

Patient has not needed a transfusion in the last 4 months

and

No evidence of disease progression

I confirm that the above details are correct:

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