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: .....

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 *- 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: .....