

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: .....