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: .....