

SPECIALTY GUIDELINE MANAGEMENT

REVLIMID (lenalidomide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Multiple myeloma in combination with dexamethasone.
2. Multiple myeloma, as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT).
3. Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.
4. Mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib.
5. Previously treated follicular lymphoma, in combination with a rituximab product
6. Previously treated marginal zone lymphoma, in combination with a rituximab product

B. Compendial Uses

1. Multiple myeloma
2. Systemic light chain amyloidosis
3. Classical Hodgkin lymphoma
4. Myelodysplastic syndrome without the 5q deletion cytogenetic abnormality
5. Myelofibrosis-associated anemia
6. POEMS Syndrome
7. Myelodysplastic syndrome/myeloproliferative neoplasms
8. Non-Hodgkin lymphoma (NHL) with any of the following subtypes:
 - a. AIDS-related diffuse large B-cell lymphoma
 - b. Primary central nervous system (CNS) lymphoma
 - c. Post-transplant lymphoproliferative disorder
 - d. Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
 - e. Diffuse large B-cell lymphoma
 - f. Follicular lymphoma
 - g. Nongastric/Gastric mucosa associated lymphoid tissue (MALT) lymphoma
 - h. Primary cutaneous B-cell lymphoma
 - i. Nodal/splenic marginal zone lymphoma
 - j. Multicentric Castleman's disease
 - k. Adult T-cell leukemia/lymphoma
 - l. Mycosis fungoides (MF)/Sezary syndrome (SS)
 - m. Angioimmunoblastic T-cell lymphoma (AITL)
 - n. Peripheral T-cell lymphoma not otherwise specified (PTCL NOS)
 - o. Enteropathy-associated T-cell lymphoma
 - p. Monomorphic epithelotropic intestinal T-cell lymphoma
 - q. Nodal peripheral T-cell lymphoma
 - r. Follicular T-cell lymphoma

- s. Primary cutaneous anaplastic large cell lymphoma (ALCL)
- t. Hepatosplenic gamma-delta T-cell lymphoma
- u. High-grade B-cell lymphomas

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

A. Multiple myeloma

Authorization of 12 months may be granted for treatment of multiple myeloma.

B. Non-Hodgkin lymphoma (NHL)

Authorization of 12 months may be granted for treatment of NHL with any of the following subtypes:

1. Second-line or subsequent therapy for relapse of AIDS-related diffuse large B-cell lymphoma
2. Relapsed or refractory primary central nervous system (CNS) lymphoma as a single agent or in combination with rituximab
3. Second-line or subsequent therapy of post-transplant lymphoproliferative disorder (non-germinal center B-cell type)
4. Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
5. Histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma after multiple lines of chemoimmunotherapy
6. Second-line or subsequent therapy for non-germinal center diffuse large B-cell lymphoma in non-candidates for transplant
7. Follicular lymphoma
8. Mantle cell lymphoma
9. Refractory or progressive nongastric MALT lymphoma as a single agent or in combination with rituximab
10. Second-line or subsequent therapy for recurrent or progressive gastric MALT lymphoma
11. Primary cutaneous B-cell lymphoma
12. Second-line or subsequent therapy for refractory or progressive nodal marginal zone lymphoma
13. Second-line or subsequent therapy for splenic marginal zone lymphoma
14. Relapsed, refractory or progressive multicentric Castleman's disease
15. Relapsed or refractory primary cutaneous anaplastic large cell lymphoma (ALCL) or cutaneous ALCL as a single agent
16. Second-line or subsequent therapy for adult T-cell leukemia/lymphoma (acute or lymphoma subtypes)
17. Mycosis fungoides (MF)/Sezary syndrome (SS)
18. Second line or subsequent therapy for relapsed or refractory angioimmunoblastic T-cell lymphoma (AITL)
19. Second-line or subsequent therapy for relapsed or refractory peripheral T-cell lymphoma not otherwise specified (PTCL NOS)
20. Second-line or subsequent therapy for relapsed or refractory enteropathy-associated T-cell lymphoma
21. Second-line or subsequent therapy for relapsed or refractory monomorphic epitheliotropic intestinal T-cell lymphoma
22. Second-line or subsequent therapy for relapsed or refractory nodal peripheral T-cell lymphoma with TFH phenotype
23. Second-line or subsequent therapy for relapsed or refractory follicular T-cell lymphoma
24. Second-line or subsequent therapy for refractory hepatosplenic gamma-delta T-cell lymphoma
25. Second line or subsequent therapy for high-grade B-cell lymphomas

C. Myelodysplastic syndrome

Authorization of 12 months may be granted as a single agent for treatment of low- to intermediate-1 risk myelodysplastic syndrome (IPSS scale) for those with symptomatic anemia.

D. Myelofibrosis-associated anemia

Authorization of 12 months may be granted for treatment of myelofibrosis-associated anemia when all of the following criteria are met:

1. The requested medication will be given as a single agent or in combination with prednisone.
2. The member has serum erythropoietin levels of either of the following:
 - a. 500 mU/mL or greater
 - b. Less than 500 mU/mL and no response or loss of response to erythropoietin stimulating agents

E. Systemic light chain amyloidosis

Authorization of 12 months may be granted for treatment of systemic light chain amyloidosis in combination with dexamethasone.

F. Classical Hodgkin lymphoma

Authorization of 12 months may be granted as third-line or subsequent therapy for treatment of relapsed or refractory classical Hodgkin lymphoma as a single agent.

G. POEMS Syndrome

Authorization of 12 months may be granted for treatment of POEMS syndrome in combination with dexamethasone.

F. Myelodysplastic/myeloproliferative neoplasms

Authorization of 12 months may be granted for treatment of myelodysplastic/myeloproliferative neoplasms with ring sideroblasts and thrombocytosis as a single agent or in combination with a hypomethylating agent.

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section II when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

IV. REFERENCES

1. Revlimid [package insert]. Summit, NJ: Celgene Corporation; May 2019.
2. The NCCN Drugs & Biologics Compendium® © 2018 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed September 23, 2019.
3. DRUGDEX® System (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: <http://www.micromedexsolutions.com> (cited: 10/09/2019).
4. The Clinical NCCN Practice Guidelines in Oncology® Multiple Myeloma (Version 1.2019). © 2018 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed October 8, 2018.
5. The Clinical NCCN Practice Guidelines in Oncology® B-cell Lymphoma (Version 5.2018) © 2018 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed October 8, 2018.
6. The Clinical NCCN Practice Guidelines in Oncology® Myelodysplastic Syndromes (Version 1.2019). © 2018 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed October 8, 2018.
7. The Clinical NCCN Practice Guidelines in Oncology® Myeloproliferative Neoplasms (Version 1.2019) © 2018 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed October 8, 2018.
8. The Clinical NCCN Practice Guidelines in Oncology® Systemic Light Chain Amyloidosis (Version 1.2018). © 2018 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed October 8, 2018.
9. The Clinical NCCN Practice Guidelines in Oncology® Hodgkin Lymphoma (Version 3.2018) © 2018 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed October 8, 2018.
10. The Clinical NCCN Practice Guidelines in Oncology T-cell Lymphomas (Version 5.2018) © 2018 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed October 8, 2018.