Pharmacy Medical Necessity Guidelines: Revlimid® (lenalidomide)

Effective: April 11, 2017 (All plans except Tufts Health RITogether)
Effective: June 1, 2017 (Tufts Health RITogether)

Prior Authorization Required | √ | Type of Review – Care Management
Not Covered | Type of Review – Clinical Review | √
Pharmacy (RX) or Medical (MED) Benefit | RX | Department to Review | RXUM

Fax Numbers:
RXUM: 617.673.0988

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
- Tufts Health Freedom Plan – large group plans
- Tufts Health Freedom Plan – small group plans

Note: For Tufts Health Plan Medicare Preferred Members, refer to the Tufts Health Plan Medicare Preferred prior authorization criteria. Background, applicable product and disclaimer information can be found on the last page.

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Multiple Myeloma
Revlimid (lenalidomide) is indicated for the treatment of multiple myeloma in combination with dexamethasone.

Revlimid (lenalidomide) is indicated as maintenance therapy in patients with multiple myeloma following autologous hematopoietic stem cell transplantation.

Transfusion-dependent Anemia
Revlimid (lenalidomide) is indicated for patients with transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities.

Mantle Cell Lymphoma
Revlimid (lenalidomide) is indicated in patients with mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib).

For all indications, Revlimid (lenalidomide) is not indicated and is not recommended for the treatment of patients with CLL outside of controlled trials.

COVERAGE GUIDELINES

The plan may authorize coverage of Revlimid (lenalidomide) for Members when all of the following criteria are met:

Transfusion-dependent Anemia
1. Documented diagnosis of transfusion dependent anemia due to myelodysplastic syndrome associated with the 5q-deletion cytogenetic abnormality
   AND
2. The prescribing physician is an oncologist

Multiple Myeloma
1. Documentation of one of the following:
   a. Diagnosis of multiple myeloma AND use in combination with dexamethasone OR
   b. Use as maintenance therapy in a Member following autologous hematopoietic stem cell transplantation
   AND
2. The prescribing physician is an oncologist or a hematologist
Mantle Cell Lymphoma
1. Documented diagnosis of mantle cell lymphoma  
2. Documentation the Member’s disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib)  
3. The prescribing physician is an oncologist

Off-label Use Coverage for Other Cancer Diagnoses
Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the Massachusetts commissioner of Insurance (commissioner) under the provisions of the "Sullivan Law": (M.G.L. c.175, s.47K ).

The plan may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a “Medically Accepted Indication” according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

Note: The plan requires prescribers to submit clinical documentation supporting the drug's effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).

In cases where the requested off-label use for the diagnosis is not recognized by the NCCN Drugs and Biologics Compendium, the plan will follow the Centers for Medicare and Medicaid Services (CMS) guidance, unless otherwise directed by the commissioner, and accept clinical documentation referenced in one of the other “Standard Reference Compendia” noted below or supported by clinical research that appears in a regular edition of a "Peer-Reviewed Medical Literature" noted below.

"Standard Reference Compendia"
1. American Hospital Formulary Service – Drug Information (AHFS-DI)
2. Thomson Micromedex DrugDex
3. Clinical Pharmacology (Gold Standard)
4. Wolters Kluwer Lexi-Drugs

"Peer Reviewed Medical Literature"
- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer
- Clinical Cancer Research
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
- Journal of Urology
- Lancet
- Lancet Oncology
- Leukemia
- The New England Journal of Medicine
- Radiation Oncology

When the plan evaluates the evidence in published, peer-reviewed medical literature, consideration will be given to the following:
1. Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
4. Whether the study is appropriate to address the clinical question.
   a. whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question (for example, in some clinical studies it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover);
   b. that non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
   c. that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

**LIMITATIONS**

1. The plan will not authorize the use of Revlimid (lenalidomide) for conditions other than those listed above without appropriate documentation.

**CODES**

None

**REFERENCES**


**APPROVAL HISTORY**

June 13, 2006: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- September 12, 2006: Added clinical coverage criteria for the diagnosis of multiple myeloma, the plan may authorize coverage of Revlimid (lenalidomide) if the following criteria are met: 1. Revlimid (lenalidomide) is used in combination with dexamethasone AND 2. The Member has received and failed to respond to at least one prior therapy AND 3. The prescribing physician is an oncologist. Added "Sullivan Law": Chapter 175: Section 47K. Off-label use of prescription drugs for cancer treatment “to clinical coverage criteria.
- September 11, 2007: No changes
- September 9, 2008: No changes
November 11, 2008: Removed criteria #3 for treatment of myelodysplastic syndrome: The Member has a documented inadequate response or inability to tolerate an appropriate trial with azacitidine (Vidaza®)

January 13, 2009: Inserted updated language for Off-label Use Coverage for Other Cancer Diagnoses

November 10, 2009: No changes

January 1, 2010: Removal of Tufts Medicare Preferred language (separate criteria have been created specifically for Tufts Medicare Preferred)

November 9, 2010: No changes

January 11, 2011: Administrative Update: Effective 4/1/2011, Off-label Use Coverage for Other Cancer Diagnoses language updated. The plan requires prescribers to submit clinical documentation supporting the drug's effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s)

November 15, 2011: No changes

October 9, 2012: No changes

August 6, 2013: Added the indication of Mantle Cell Lymphoma as well the criteria "Tufts Health Plan may authorize coverage of Revlimid (lenalidomide) for the diagnosis of mantle cell lymphoma when the following criteria are met: The Member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib).

October 15, 2013: Added "The prescribing physician must be an oncologist" to the Mantle Cell lymphoma indication.

October 7, 2014: No changes

April 14, 2015: Removed the requirement of failure of one prior therapy for the treatment of multiple myeloma.

January 1, 2016: Administrative change to rebranded template applicable to Tufts Health Direct

April 12, 2016: Added limitation #1 “The plan will not authorize the use of Revlimid (lenalidomide) for conditions other than those listed above without appropriate documentation”.


BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. For Tufts Health Plan Medicare Preferred, refer to Tufts Health Plan Medicare Preferred prior authorization criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.