Drug Policy:

Revlimid™ (lenalidomide)

POLICY NUMBER UM ONC_1193	SUBJECT Revlimid™ (lenalidomide)		DEPT/PROGRAM UM Dept	PAGE 1 of 4
DATES COMMITTEE REVIEWED 01/04/12, 10/13/13, 12/03/14, 01/19/15, 07/25/16, 06/09/17, 06/13/18, 05/08/19, 12/11/19, 03/11/20, 01/13/21, 04/14/21, 11/15/21, 03/09/22, 05/11/22, 06/08/22, 07/13/22, 10/12/22, 11/09/22, 03/08/23, 05/10/23, 10/11/23, 12/13/2023	**APPROVAL DATE** December 13, 2023	**EFFECTIVE DATE** December 22, 2023	**COMMITTEE APPROVAL DATES** 01/04/12, 10/13/13, 12/03/14, 01/19/15, 07/25/16, 06/09/17, 06/13/18, 05/08/19, 12/11/19, 03/11/20, 01/13/21, 04/14/21, 11/15/21, 03/09/22, 05/11/22, 06/08/22, 07/13/22, 10/12/22, 11/09/22, 03/08/23, 05/10/23, 10/11/23, 12/13/2023	
PRIMARY BUSINESS OWNER: UM		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee		
NCQA STANDARDS UM 2		**ADDITIONAL AREAS OF IMPACT**		
CMS REQUIREMENTS	**STATE/FEDERAL REQUIREMENTS**		**APPLICABLE LINES OF BUSINESS** Commercial, Exchange, Medicaid	

I. PURPOSE

To define and describe the accepted indications for Revlimid (lenalidomide) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

A. Continuation requests for a not-approvable medication shall be exempt from this NCH policy provided:

1. The requested medication was used within the last year, AND
2. The member has not experienced disease progression and/or no intolerance to the requested medication, AND
3. Additional medication(s) are not being added to the continuation request.

B. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)

1. NOTE: Lenalidomide +/- rituximab/rituximab biosimilar is not supported by Evolent Policy for Revlimid(lenalidomide) for the treatment of CLL/SLL. This policy position is based on the lack of Level 1 Evidence (randomized clinical trial and/or meta-analyses) to show superior

outcomes with the above regimen compared to Evolent recommended alternatives agents/regimens, including but not limited to regimens at http://pathways.newcenturyhealth.com.

C. Multiple Myeloma (MM)

1. The member has multiple myeloma and Revlimid (lenalidomide) may be used in the following clinical settings:
    a. Initial/First Line Therapy
        i. In combination with bortezomib +/- steroid
        ii. In combination with daratumumab + bortezomib +/- steroid (for transplant eligible members only)
        iii. In combination with daratumumab +/- steroid for transplant-ineligible patients
        iv. In combination with cyclophosphamide +/- steroid

        NOTE: [Daratumumab + carfilzomib + lenalidomide +/- dexamethasone] is not supported by Evolent Policy for Revlimid (lenalidomide) for initial therapy of newly diagnosed multiple myeloma. This policy position is based on the lack of Level 1 Evidence (randomized clinical trial and/or meta-analyses) to show superior outcomes compared to Evolent recommended alternative agents/regimens, including but not limited to regimens at http://pathways.newcenturyhealth.com.

    b. Subsequent Line therapy and Maintenance Therapy:
        i. Maintenance therapy as a single agent:
            - After completion of therapy for newly diagnosed or relapsed/refractory disease OR
            - After completion of autologous stem cell transplant.
        ii. For relapsed or refractory disease as ONE of the following:
            - As a single agent or with dexamethasone
            - With Darzalex/Darzalex Faspro (daratumumab) +/- dexamethasone
            - With bortezomib +/- dexamethasone
            - With Ninlaro (ixazomib) +/- dexamethasone
            - With Kyprolis (carfilzomib) +/- dexamethasone
            - With Empliciti (elotuzumab) +/- dexamethasone
            - With bendamustine +/- dexamethasone
            - With Cytoxan (cyclopohosphamide) +/- dexamethasone.

D. Myelodysplastic Syndrome (MDS)

1. The member has very low, low, or intermediate risk MDS associated with symptomatic anemia and Revlimid (lenalidomide) is being used as ONE of the following:
    a. In members with del(5q) chromosomal abnormality with or without an ESA.
    b. In members without del(5q) chromosomal abnormality with or without an ESA.

E. Non-Hodgkin's Lymphoma (NHL)

1. The member has Non-Hodgkin's Lymphoma including Follicular Lymphoma, Nodal Marginal Zone Lymphoma, Mantle Cell Lymphoma, and Splenic Marginal Zone Lymphoma AND Revlimid (lenalidomide) may be used for relapsed/refractory disease as second-line or subsequent therapy for recurrent or progressive disease, with or without rituximab/rituximab biosimilar.

2. NOTE: The following regimens are not supported by Evolent Policy for Revlimid (lenalidomide) for the following treatment settings:
    a. Diffuse Large B Cell Lymphoma (DLBCL) maintenance: single agent Revlimid (lenalidomide).
    b. Marginal Zone Lymphomas (MZL), initial therapy: Lenalidomide + rituximab (any rituximab product).
    c. Mantle Cell Lymphoma (MCL), second line and subsequent therapy: ibrutinib + lenalidomide + rituximab (any rituximab product).
    d. The above policy positions are based on the lack of Level 1 Evidence (randomized clinical trial and/or meta-analyses) to show superior outcomes compared to Evolent recommended alternatives agents/regimens, including but not limited to regimens at http://pathways.newcenturyhealth.com.

III. EXCLUSION CRITERIA

A. Member has disease progression while taking Revlimid (lenalidomide).

B. Dosing exceeds single dose limit of Revlimid (Lenalidomide) 25 mg (for DLBCL/FL/MZL/MCL), 10 mg (for MDS), or 25 mg (for MM).

C. Treatment exceeds the maximum limit of 21 (2.5 mg), 21 (5 mg), 21 (10 mg), 21 (15 mg), 21 (20 mg), or 21 (25 mg) capsules/month.

D. Investigational use of Revlimid (lenalidomide) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
    1. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
    2. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
    3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
    4. Whether the experimental design, considering 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).
    5. 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.
    6. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
    7. That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

IV. MEDICATION MANAGEMENT

A. Please refer to the FDA label + package insert for details regarding these topics.

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

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N. Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

O. NCQA UM 2023 Standards and Elements.