Applicable Drugs: Revlimid (lenalidomide)

Preferred: lenalidomide (generic)

Non-preferred: Revlimid

Date of Origin: 2/1/2013

Date Last Reviewed / Revised: 2/17/2026

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met.)

I. Documentation of one of the following FDA-approved diagnoses A through E AND must meet all criteria listed under the applicable diagnosis:

FDA-Approved Indication(s)

A. Myelodysplastic Syndrome (MDS)

1. Documentation of transfusion-dependent anemia (defined as administration of 2 or more units of red blood cells [RBCs] in the previous 8 weeks) due to low- or intermediate-1-risk MDS associated with a deletion 5q (del 5q) cytogenetic abnormality with or without additional cytogenetic abnormalities.

B. Multiple Myeloma (MM) and criteria 1 or 2 is met:

1. Revlimid (lenalidomide) is used in combination with dexamethasone or documented intolerance or contraindication to a corticosteroid.
2. Revlimid (lenalidomide) is used as maintenance therapy following autologous hematopoietic stem cell transplantation.

C. Mantle Cell Lymphoma (MCL)

1. Documentation of disease progression, relapse, or intolerance to at least 2 other MCL therapies, one of which included Velcade (bortezomib). See Appendix for first-line therapy options for MCL.

D. Follicular Lymphoma (FL)

1. Documentation of disease progression, relapse, or intolerance to at least 1 other FL regimen. See Appendix for first-line therapy options for FL.
2. Revlimid (lenalidomide) is used in combination with a rituximab product.

E. Marginal Zone Lymphoma (MZL)

1. Documentation of disease progression, relapse, or intolerance to at least 1 other MZL therapy. See Appendix for first-line therapy options for MZL.
2. Revlimid (lenalidomide) is used in combination with a rituximab product.

Other Uses with Supportive Evidence

F. Castleman Disease

G. Histiocytic Neoplasms
    1. Langerhans Cell Histiocytosis
    2. Rosai-Dorfman Disease
H. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
I. Primary Central Nervous System Cancers
J. Classic Follicular Lymphoma
K. Marginal Zone Lymphoma
L. Mantle Cell Lymphoma
M. Diffuse Large B-Cell Lymphoma
N. Classic Hodgkin Lymphoma
O. Systemic Light Chain Amyloidosis
P. Multiple Myeloma
Q. T-Cell Lymphomas
R. Kaposi Sarcoma
S. Myelodysplastic Syndromes
T. Post Transplant Lymphoproliferative Disorders (PTLD)
U. Cutaneous Lymphomas

II. Minimum age requirement: 18 years old.

III. Treatment must be prescribed by or in consultation with an oncologist or a hematologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented failure, intolerance, or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Quantities of up to 30 capsules (any combination of 2.5 mg, 5 mg, 10 mg, 15 mg, 20 mg, or 25 mg) per 30 days.
- Multiple Myeloma in combination with dexamethasone
    - 25 mg orally once daily on Days 1 to 21 of repeated 28-day cycles
- Multiple Myeloma maintenance therapy following autologous hematopoietic stem cell transplantation (auto-HSCT)
    - 10 mg orally once a day continuously (Days 1 to 28 of repeated 28-day cycles) for 3 cycles, then increase to 15 mg once a day if tolerated
- Myelodysplastic Disease
    - 10 mg orally once a day
- Follicular Lymphoma or Marginal Zone Lymphoma
    - 20 mg orally once a day on Days 1 through 21 of repeated 28-day cycles for up to 12 cycles in combination with rituximab
- Mantle Cell Lymphoma
    - 25 mg orally once a day on Days 1 to 21 of repeated 28-day cycles

APPROVAL LENGTH

- **Authorization:**
    - Myelodysplastic Syndrome (MDS): 3 months.
    - Multiple Myeloma (MM), Mantle Cell Lymphoma (MCL), Follicular Lymphoma (FL), or Marginal Zone Lymphoma (MZL): 1 year.
- **Re-Authorization:** 1 year. An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and does not show evidence of progressive disease (for MDS, medication must be shown to be effective in significantly decreasing the number of red blood cell transfusions required).

APPENDIX

- N/A

REFERENCES

1. Revlimid. Prescribing information. Celgene Corporation. 2023. Accessed *February 8, 2026.* https://packageinserts.bms.com/pi/pi_revlimid.pdf.
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Myelodysplastic Syndromes. Version *3.2026*. Updated *January 12, 2026*. Accessed *February 8, 2026*. http://www.nccn.org/professionals/physician_gls/PDF/mds.pdf.

3. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Multiple Myeloma. Version *5.2026*. Updated *January 9, 2026*. Accessed *February 8, 2026*. https://www.nccn.org/professionals/physician_gls/PDF/myeloma.pdf.
4. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. B-Cell Lymphomas Version *1.2026*. Updated *December 22, 2025*. Accessed *February 8, 2026*. https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf.
5. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Castleman Disease Version *1.2026*. Updated *November 24.2025.* Accessed *February 8, 2026*. https://www.nccn.org/professionals/physician_gls/pdf/castleman.pdf
6. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Histiocytic Neoplasms. Version *2.2025*. Updated *November 21, 2025*. Accessed *February 8, 2026*. https://www.nccn.org/professionals/physician_gls/pdf/histiocytic_neoplasms.pdf
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10. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Systemic Light Chain Amyloidosis. Version *1.2026*. Updated June *11, 2025*. Accessed *February 9, 2026*. https://www.nccn.org/professionals/physician_gls/pdf/amyloidosis.pdf
11. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. T-Cell Lymphomas Version *1.2026*. Updated *December 9, 2025*. Accessed *February 9, 2026*. https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf
12. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Kaposi Sarcoma Version *2.2026*. Updated *September 16.2025*. Accessed *February 9, 2026*. https://www.nccn.org/professionals/physician_gls/pdf/kaposi.pdf

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.