PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Oncology (Oral – Immunomodulator) – Lenalidomide Preferred Specialty Management Policy
- Revlimid® (lenalidomide capsules – Celgene/Bristol Myers Squibb, generic)

REVIEW DATE: 10/01/2025; effective 02/01/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Lenalidomide, a thalidomide analog, is indicated for the following uses in adults:[1]
- **Follicular lymphoma**, previously treated, in combination with a rituximab product.
- **Mantle cell lymphoma**, in patients whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib.
- **Marginal zone lymphoma**, previously treated, in combination with a rituximab product.
- **Multiple myeloma**, as maintenance following autologous hematopoietic stem cell transplantation.
- **Multiple myeloma**, treatment, in combination with dexamethasone.

- **Myelodysplastic syndrome**, for transfusion-dependent anemia due to low- or intermediate-1-risk disease, associated with a deletion 5q abnormality with or without cytogenetic abnormalities.

POLICY STATEMENT
This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Oncology (Oral – Immunomodulator) – Lenalidomide Prior Authorization Policy* criteria. The program also directs the patient to try one Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for the duration noted below. If the patient meets the standard *Oncology (Oral – Immunomodulator) – Lenalidomide Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for a Preferred Product will be authorized.

Documentation: Documentation is required for previous use of the preferred drug as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

Preferred Products:	generic lenalidomide capsules
Non-Preferred Products:	Revlimid

Oncology (Oral – Immunomodulator) – Lenalidomide Preferred Specialty Management Policy non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Revlimid	**1.** Approve for 1 year if the patient meets ALL of the following (A, B, and C): **A)** Patient meets the standard *Oncology (Oral – Immunomodulator) – Lenalidomide Prior Authorization Policy* criteria; AND **B)** Patient has tried generic lenalidomide capsules; AND **[documentation required]** **C)** Patient cannot continue to use the preferred product due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the brand and bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** If the patient has met the standard *Oncology (Oral – Immunomodulator) – Lenalidomide Prior Authorization Policy* criteria (1A), but has not met exception criteria (1B) and/or (1C) above for brand Revlimid: approve generic lenalidomide capsules.

REFERENCES

1. Revlimid® capsules [prescribing information]. Summit, NJ: Celgene; March 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	Effective 02/01/2026.	10/01/2025