

<b>Clinical Policy Title:</b>	
<b>Policy Number:</b>	RxA.350
<b>Drug(s) Applied:</b>	Alimta®
<b>Original Policy Date:</b>	03/06/2020
<b>Last Review Date:</b>	09/14/2021
<b>Line of Business Policy Applies to:</b>	All lines of business

## Background

Pemetrexed (Alimta®) is an antifolate antineoplastic agent.

Alimta® is indicated for:

- Treatment of locally advanced or metastatic non squamous non-small cell lung cancer (NSCLC):
  - o In combination with cisplatin as initial treatment;
  - o In combination with platinum therapy and pembrolizumab as initial treatment of patients with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations;
  - o As a single agent as maintenance treatment for disease that has not progressed after four cycles of platinum-based first-line chemotherapy;
  - o As a single agent after prior chemotherapy.
- Initial treatment of malignant pleural mesothelioma, in combination with cisplatin, for patients whose disease is unresectable or who are otherwise not candidates for curative surgery.

Limitation(s) of use: Alimta® is not indicated for the treatment of patients with squamous cell non-small cell lung cancer.

## Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
pemetrexed (Alimta®)	NSCLC	500 mg/m <sup>2</sup> intravenously on Day 1 of each 21-day cycle as a single agent or in combination with cisplatin, or platinum therapy and pembrolizumab	500 mg/m <sup>2</sup> intravenous infusion every 21 days
	Malignant pleural mesothelioma	500 mg/m <sup>2</sup> intravenously on Day 1 of each 21-day cycle in combination with cisplatin	500 mg/m <sup>2</sup> intravenous infusion every 21 days

## Dosage Forms

- Single-dose vial for injection: 100 mg, 500 mg.

## Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

**I. Initial Approval Criteria**

**A. Non-Small Cell Lung Cancer or Mesothelioma (must meet all):**

1. Diagnosis of one of the following (a or b):
  - a. Non-squamous NSCLC;
  - b. Malignant pleural mesothelioma;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 500 mg per m<sup>2</sup> every 21 days;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

\*Prescribed regimen must be FDA-approved or recommended by NCCN.

**Approval duration**

**Commercial:** 6 months

**Medicaid:** 6 months

**B. Thymoma or Thymic Carcinoma (off-label) (must meet all):**

1. Diagnosis of thymoma or thymic carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Prescribed as second line therapy (initial treatment may include surgery, radiation therapy, chemotherapy);
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).\*

\*Prescribed regimen must be FDA-approved or recommended by NCCN.

**Approval duration**

**Commercial:** 6 months

**Medicaid:** 6 months

**C. Ovarian/Fallopian Tube/Primary Peritoneal Cancer (off-label) (must meet all):**

1. Diagnosis of ovarian, fallopian tube, or primary peritoneal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. Disease is persistent or recurrent;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).\*

\*Prescribed regimen must be FDA-approved or recommended by NCCN.

**Approval duration**

**Commercial:** 6 months

**Medicaid:** 6 months

**D. Primary Central Nervous System Lymphoma (off-label) (must meet all):**

1. Diagnosis of relapsed or refractory central nervous system lymphoma;

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).\*

\*Prescribed regimen must be FDA-approved or recommended by NCCN.

**Approval duration**

**Commercial:** 6 months

**Medicaid:** 6 months

**E. Urothelial Carcinoma (off-label) (must meet all):**

1. Diagnosis of urothelial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years of age or older;
4. Prescribed as subsequent systemic therapy;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).\*

\*Prescribed regimen must be FDA-approved or recommended by NCCN.

**Approval duration**

**Commercial:** 6 months

**Medicaid:** 6 months

**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**

1. Member is currently receiving medication that has been authorized by RxAdvance or member has met the initial approval criteria for a covered indication and has had at least one dose in the last 90 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):\*
  - a. New dose does not exceed 500 mg/m<sup>2</sup> every 21 days;
  - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

\*Prescribed regimen must be FDA-approved or recommended by NCCN.

**Approval duration**

**Commercial:** 12 months

**Medicaid:** 6 months

**III. Appendices**

**APPENDIX A: Abbreviation/Acronym Key**

ALK: Anaplastic lymphoma kinase

EGFR: Epidermal growth factor receptor

NSCLC: Non-small cell lung cancer

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

**APPENDIX B: Therapeutic Alternatives**

- Not applicable.

**APPENDIX C: Contraindications/Boxed Warnings**

- Contraindication(s):
  - o History of severe hypersensitivity reaction to pemetrexed.
- Boxed warning(s):
  - o None reported.

**APPENDIX D: General Information**

- Myelosuppression: Can cause severe bone marrow suppression resulting in cytopenia and an increased risk of infection. Do not administer Alimta® when the absolute neutrophil count is less than 1500 cells/mm<sup>3</sup> and platelets are less than 100,000 cells/mm<sup>3</sup>. Initiate supplementation with oral folic acid and intramuscular vitamin B12 to reduce the severity of hematologic and gastrointestinal toxicity of Alimta®.
- Renal Failure: Can cause severe, and sometimes fatal, renal failure. Do not administer when creatinine clearance is less than 45 mL/min.
- Bullous and Exfoliative Skin Toxicity: Permanently discontinue for severe and life-threatening bullous, blistering or exfoliating skin toxicity.
- Interstitial Pneumonitis: Withhold for acute onset of new or progressive unexplained pulmonary symptoms. Permanently discontinue if pneumonitis is confirmed.
- Radiation Recall: Can occur in patients who received radiation weeks to years previously; permanently discontinue for signs of radiation recall.
- Embryo-Fetal Toxicity: Can cause fetal harm. Advise patients of the potential risk to a fetus and to use effective contraception.

**References**

1. Alimta® Prescribing Information. Indianapolis, IN: Eli Lilly Pharmaceuticals; January 2019. Available at: [www.alimta.com](http://www.alimta.com). Accessed June 1, 2021.
2. Non-small cell lung cancer (Version 4.2021). National Comprehensive Cancer Network Guidelines. Available at [https://www.nccn.org/professionals/physician\\_gls/pdf/nscl.pdf](https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf). Accessed June 1, 2021.
3. Malignant pleural mesothelioma (Version 2.2021). National Comprehensive Cancer Network Guidelines. Available at [https://www.nccn.org/professionals/physician\\_gls/pdf/mpm.pdf](https://www.nccn.org/professionals/physician_gls/pdf/mpm.pdf). Accessed June 1, 2021.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed June 1, 2021.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed June 1, 2021.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1) Policy title was updated. 2) Indications were updated. 3) Initial Approval criteria updated. 4) Continued Therapy Approval criteria II.A.1 was rephrased. 5) Appendices updated. 6) References were updated.	07/28/2020	09/14/2020

<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1) Statement about provider sample “The provision of provider samples does not guarantee coverage...” was added to Clinical Policy.</li> <li>2) Initial Approval Criteria and Continued Therapy Criteria approval duration was updated to remove HIM approval duration.</li> <li>3) Appendix A was updated to include NCCN.</li> <li>4) Appendix D was updated to include warnings and precautions “Myelosuppression: Can cause severe bone marrow suppression resulting in cytopenia...”</li> <li>5) References were reviewed and updated.</li> </ol>	<p>06/01/2021</p>	<p>09/14/2021</p>
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