Clinical Policy: Pemetrexed (Alimta)

Reference Number: CP.PHAR.368
Effective Date: 10.31.17
Last Review Date: 02.18
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Pemetrexed (Alimta®) is an antifolate antineoplastic agent.

FDA Approved Indication(s)
Alimta is indicated for the treatment of:

- Locally advanced or metastatic nonsquamous non-small cell lung cancer (NSCLC):
  - As initial treatment in combination with cisplatin;
  - Maintenance treatment of patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy;
  - After prior chemotherapy as a single-agent;
- Mesothelioma in combination with cisplatin.

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

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Alimta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of metastatic nonsquamous NSCLC or mesothelioma;
2. Prescribed by or in consultation with an oncologist;
3. Request meets one of the following (a or b):
   a. Dose does not exceed 500mg/m^2 administered 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*).

Approval duration: 6 months

B. Thymomas or Thymic Carcinomas (off-label) (must meet all)**:**

1. Diagnosis of thymomas or thymic carcinomas;
2. Prescribed by or in consultation with an oncologist:
3. Prescribed as a second line therapy following initial treatment *(initial treatment may include surgery, radiation therapy , chemotherapy)*;

4. Request meets one of the following (a or b):
   a. Dose does not exceed 500mg/m^2 administered 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*).

Approval duration: 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. Disease is persistent or recurrent;
4. Failure of or presence of clinically significant adverse effects or contraindication to FDA-approved treatments (*see Appendix B*), unless such therapies are determined to be inappropriate;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 500mg/m^2 administered 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*).

Approval duration: 6 months

D. Primary CNS Lymphoma (off-label) (must meet all)**:**
1. Diagnosis of primary CNS lymphoma;
2. Prescribed by or in consultation with an oncologist;
3. Prescribed for relapsed or refractory disease in patients previously treated with high-dose methotrexate-based regimen;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 500mg/m^2 administered 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*).

Approval duration: 6 months

E. Bladder Cancer (off-label) (must meet all)**:**
1. Diagnosis of recurrent or metastatic bladder cancer (including upper genital urinary tract tumor, urothelial carcinoma of the prostate, and carcinoma of the urethra);
2. Prescribed by or in consultation with an oncologist;
3. Prescribed as subsequent systemic therapy following failure of or presence of clinically significant adverse effects or contraindication to other recommended alternative therapies (*see Appendix B*), unless such therapies are determined to be inappropriate;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 500mg/m^2 administered 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*).

Approval duration: 6 months

F. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit or documentation supports that member has received Alimta for any of the covered indications and has had at least one dose in the last 90 days;
2. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 500mg/m^2 administered 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*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CNS: central nervous system
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be formulary agents and may require prior authorization.

Indication	Preferred Agents	Dosage
Ovarian, fallopian tube, primary peritoneal cancer	Hexalen® (altretamine)	Oral: 260 mg/m^2/day in 4 divided doses for 14 or 21 days of a 28-day cycle
	Avastin® (bevacizumab)	15 mg/kg every 3 weeks (in combination with carboplatin and gemcitabine for 6 to 10 cycles or with carboplatin and paclitaxel for 6 to 8 cycles) then continue with bevacizumab (monotherapy) until disease progression or unacceptable toxicity

Indication	Preferred Agents	Dosage
	carboplatin	360 mg/m^2 IV q 4 weeks (as a single agent) or 300 mg/m^2 IV q 4 weeks (in combination with cyclophosphamide) for 6 cycles
	cisplatin	Single agent: 100 mg/m^2 q 4 weeks Combination therapy: 75 to 100 mg/m^2 q 4 weeks
	cyclophosphamide	600 to 1000 mg/m^2 IV in combination with doxorubicin, cisplatin, and/or other agents
	doxorubicin (Adriamycin®)	50 mg/m^2 IV once every 28 days until disease progression or unacceptable toxicity
	gemcitabine (Gemzar®)	1000 mg/m^2 IV over 30 minutes days 1 and 8; repeat cycle every 21 days (in combination with carboplatin)
	melphalan (Alkeran®)	0.2 mg/kg/day PO for 5 days, repeat every 4 to 5 weeks
	Zejula® (niraparib)/ Lynparza® (olaparib)	300 mg PO QD or BID, continue until disease progression or unacceptable toxicity
	paclitaxel	135 or 175 mg/m^2 IV over 3 hours every 3 weeks
	Rubraca® (rucaparib)	600 mg PO BID until disease progression or unacceptable toxicity.
	thiotepa (Tepadina®)	0.3 to 0.4 mg/kg IV repeated every 1 to 4 weeks. Adjust the maintenance dose weekly based on blood counts
	topotecan (Hycamtin®)	1.5 mg/m^2/day IV for 5 consecutive days every 21 days
	capecitabine (Xeloda®)	1,000 mg/m^2 PO BID on days 1 to 14 of a 3-week cycle until disease progression or unacceptable toxicity
	docetaxel (Taxotere®)	60 mg/m^2 IV q 3 weeks (in combination with carboplatin) for up to 6 cycles
	oxaliplatin	130 mg/m^2 IV once every 3 weeks until disease progression or unacceptable toxicity
	tamoxifen	20 mg twice daily
	vinorelbine (Navelbine®)	25 mg/m^2 IV every 7 days or 30 mg/m^2 IV on days 1 and 8 of a 21-day treatment cycle until disease progression or unacceptable toxicity
Bladder cancer	Tecentriq® (atezolizumab)	1,200 mg IV q 3 weeks, continue until disease progression or unacceptable toxicity
	Bacillus Calmetter-Guérin (BCG) Live	One dose (vial) instilled into bladder (retain for up to 2 hours) q weekly for 6 weeks

Indication	Preferred Agents	Dosage
		beginning at least 14 days after biopsy, followed by maintenance therapy
	cisplatin	50 to 70 mg/m^2 IV q 3 to 4 weeks; heavily pretreated patients: 50 mg/m^2 IV every 4 weeks
	doxorubicin (Adriamycin)	*Dose-dense MVAC regimen:* 3 mg/m^2 IV on day 2, every 14 days (in combination with methotrexate, vinblastine, and cisplatin)
	thiotepa (Tepadina)	60 mg intravesically once weekly for 4 weeks
	Valstar® (valrubicin)	800 mg intravesically once weekly (retain for 2 hours) for 6 weeks
	paclitaxel	150 mg/m^2 IV q 2 weeks (in combination with gemcitabine) or 200 mg/m^2 IV over 1 hour q 3 weeks (in combination with gemcitabine) for 6 cycles
	vinblastine	*Dose-dense MVAC regimen*: 3 mg/m^2 IV on day 2, every 14 days (in combination with methotrexate, doxorubicin, cisplatin, and filgrastim) until disease progression or unacceptable toxicity
	carboplatin	IV: Target AUC 5 every 3 weeks (in combination with gemcitabine or Target AUC 6 every 3 weeks (in combination with paclitaxel)
	gallium	300mg/m^2 IV infused over 24 hours for 5 days along with vinblastine and ifosfamide
	ifosfamide (Ifex®)	1,500 mg/m^2/day IV for 5 days every 3 weeks (with mesna) until disease progression
	methotrexate	CMV regimen**:** 30 mg/m^2 IV on days 1 and 8 every 3 weeks for 3 cycles (in combination with cisplatin, vinblastine and leucovorin rescue) or dose-dense MVAC regimen
	gemcitabine (Gemzar)	1000 mg/m^2 IV over 30 to 60 minutes on days 1, 8, and 15; repeat cycle every 28 days
	Photofrin® (porfimer)	1.5 mg/kg IV given 48 to 72 hours prior to whole bladder photodynamic therapy (PDT)
	mitomycin	20 mg IV weekly for 6 weeks, followed by 20 mg monthly for 3 years; retain in bladder for 1 to 2 hours or 40 mg weekly for 6 weeks; retain in bladder for 2 hours

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	500 mg/m^2 IV on Day 1 of each 21-day cycle in combination with cisplatin 75 mg/m^2 IV beginning 30 minutes after Alimta administration. Can be given as a single agent,	500 mg/m^2 IV infusion every 21 days
Mesothelioma	500 mg/m^2 IV on Day 1 of each 21-day cycle in combination with cisplatin 75 mg/m^2 IV beginning 30 minutes after Alimta administration. Can be given as a single agent,	500 mg/m^2 IV infusion every 21 days

VI. Product Availability

Vial for injection: 100 mg and 500 mg

VII. References

1. Alimta Prescribing Information. Indianapolis, IN: Eli Lilly Pharmaceuticals; September 2013. Available at: www.Alimta.com. Accessed October 19, 2017.
2. Alimta Drug Monograph. Clinical Pharmacology. Accessed Oct 2017. http://www.clinicalpharmacology-ip.com
3. Non-small cell lung cancer (Version 9.2017). In: National Comprehensive Cancer Network Guidelines. Available at www.NCCN.org. Accessed Oct 17, 2017.
4. Malignant pleural mesothelioma (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at www.NCCN.org. Accessed Oct 17, 2017
5. Ettinger DS, Wood DE, Akerley W, et al. NCCN Guidelines Insights: malignant pleural mesothelioma, Version 3. 2016. J Natl Compr Canc Netw. 2016; 14(7):825–836.
6. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed Oct 24, 2017.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9305	Injection, pemetrexed, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.31.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.

Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.