Clinical Policy: Pralatrexate (Folotyn)

Reference Number: CP.PHAR.313
Effective Date: 02.01.17
Last Review Date: 11.17
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description
Pralatrexate injection (Folotyn®) is a folate analog metabolic inhibitor.

FDA Approved Indication(s)
Folotyn is indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL).

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 Folotyn is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria
A. Non-Hodgkin T-Cell Lymphomas
1. Age ≥ 18 years;
2. Diagnosis of one of the following:
   a. A peripheral T-cell lymphoma (PTCL):
      i. Meets (a or b):
         a) FDA approved use:
            1) Relapsed or refractory PTCL;
         b) NCCN recommended use:
            1) Second-line or subsequent therapy for relapsed or refractory angioimmunoblastic T-cell lymphoma, PTCL not otherwise specified, anaplastic large cell lymphoma (ALCL), enteropathy-associated T-cell lymphoma, or monomorphic epitheliotropic intestinal T-cell lymphoma;
   b. Mycosis fungoides (MF) or Sezary syndrome (SS);
      i. NCCN recommended use (a or b):
         a) First-line therapy in low doses for (1, 2 or 3):
            1) Stage IB-IIA MF with histologic evidence of folliculotropic or large cell transformation or stage IIB with generalized tumor lesions, with or without skin-directed therapy;
            2) Stage IV non-Sezary or visceral disease ;

3) Stage III MF or SS which has progressed or is refractory to multiple previous therapies;
b) Single-agent therapy for tumors with histologic evidence of large cell transformation and aggressive growth rate for (1 or 2):
1) Stage IB-IIA MF with histologic evidence of folliculotropic or large cell transformation or stage IIB with generalized tumor lesions, with or without skin-directed therapy;
2) Stage IV non-Sezary or visceral disease;
c. Primary cutaneous CD30+ T-cell lymphoproliferative disorder;
i. NCCN recommended use - 1-2A:
a) Single-agent therapy for primary cutaneous ALCL with multifocal lesions or cutaneous ALCL with regional nodes as (1 or 2) (does not include systemic ALCL):
1) Primary treatment;
2) Therapy for relapsed or refractory disease;
d. Adult T-cell leukemia/lymphoma;
i. NCCN recommended use:
a) Second-line therapy as a single agent for nonresponders to first-line therapy for acute disease or lymphoma or as subsequent therapy after high dose therapy/autologous stem cell rescue (HDT/ASCR);

3. Request meets one of the following (a or b):
a. PTCL: Dose does not exceed 30 mg/m^2 once weekly for 6 weeks in 7-week cycles;
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. Other diagnoses/indications

1. Refer to CP.PHAR.57 for specialty 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 initial approval criteria has been met;
2. Responding positively to therapy (e.g., no disease progression or unacceptable toxicity);
3. If request is for a dose increase, request meets one of the following (a or b):
a. New dose does not exceed 30 mg/m^2 once weekly for 6 weeks in 7-week cycles;
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.PHAR.57 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.PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALCL: anaplastic large cell lymphoma
FDA: Food and Drug Administration
HDT/ASCR: high dose therapy/autologous stem cell rescue
MF: mycosis fungoides
NCCN: National Comprehensive Cancer Network
PTCL: peripheral T-cell lymphoma
SS: Sezary syndrome

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PTCL	Pretreatment vitamin supplementation • Folic Acid: Patients should take folic acid 1.0-1.25 mg orally once daily beginning 10 days before the first dose of Folotyn. Continue folic acid during the full course of therapy and for 30 days after the last dose of Folotyn. • Vitamin B12: Administer vitamin B12 1 mg intramuscularly within 10 weeks prior to the first dose of Folotyn and every 8-10 weeks thereafter. Subsequent vitamin B12 injections may be given the same day as treatment with Folotyn. Dosing • 30 mg/m2 as an intravenous push over 3-5 minutes via the side port of a free-flowing 0.9% Sodium Chloride Injection, intravenous line once weekly for 6 weeks in 7-week cycles until progressive disease or unacceptable toxicity. Renal impairment • If severe renal impairment (eGFR 15 to < 30 mL/min/1.73 m2), the recommended dose is 15 mg/m2.	30 mg/m^2 once weekly.

VI. Product Availability

Single-dose vial: 20 mg/mL (1 and 2 mL vials)

VII. References

1. Folotyn Prescribing Information. Westminster, CO: Spectrum Pharmaceuticals, Inc.; November 2016. Available at: http://www.folotyn.com/HCP/downloads/folotyn-pi_Nov2016.pdf. Accessed August 2017.
2. Pralatrexate. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed August 2017.
3. Peripheral T-cell lymphoma (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed August 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
J9307	Injection, pralatrexate, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.182.Excellus Oncology.	01.01.17	02.17
Age and dosing added. Safety information removed. NCCN recommended uses added separately.	09.05.17	11.17

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.