Clinical Policy: Pemetrexed (Alimta)
Reference Number: ERX.SPA.307
Effective Date: 03.01.19
Last Review Date: 02.19

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:
• Treatment of locally advanced or metastatic nonsquamous non-small cell lung cancer (NSCLC):
  o In combination with cisplatin as initial treatment
  o In combination with carboplatin and pembrolizumab as initial treatment
  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 NSCLC.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ 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 one of the following (a or b):
         a. Nonsquamous NSCLC;
         b. Malignant pleural mesothelioma;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Request meets one of the following (a or b):
         a. Dose does not exceed 500 mg/m² 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. 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 ≥ 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*).

**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. Age ≥ 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*).

**Approval duration: 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;
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*).

**Approval duration: 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;
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*).

**Approval duration: 6 months**

**F. Other diagnoses/indications**
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Alimta for a covered indication and has received this medication for at least 30 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/m² 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 a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less); or**
2. Refer to ERX.PA.01 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 – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>NSCLC</td>
<td>500 mg/m² IV on Day 1 of each 21-day cycle as a single agent or in combination with cisplatin, or carboplatin and pembrolizumab</td>
<td>500 mg/m² IV infusion every 21 days</td>
</tr>
<tr>
<td>Malignant pleural mesothelioma</td>
<td>500 mg/m² IV on Day 1 of each 21-day cycle in combination with cisplatin</td>
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</table>

VI. Product Availability
Vial for injection: 100 mg, 500 mg

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
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<tbody>
<tr>
<td>Policy created.</td>
<td>11.13.18</td>
<td>02.19</td>
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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.
This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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