Clinical Policy: Pemetrexed (Alimta, Pemfexy)

Reference Number: LA.PHAR.368
Effective Date:
Last Review Date: 03.21 Coding Implications
Line of Business: Medicaid Revision Log

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

Description

Pemetrexed (Alimta®, Pemfexy™) is an antifolate antineoplastic agent.

FDA Approved Indication(s)

Alimta is indicated:

- In combination with pembrolizumab and platinum chemotherapy, for the initial treatment of patients with metastatic non-squamous NSCLC, with no EGFR or ALK genomic tumor aberrations.

Alimta and Pemfexy are indicated:

- In combination with cisplatin for the initial treatment of patients with locally advanced or metastatic, non-squamous, non-small cell lung cancer (NSCLC).
- As a single agent for the maintenance treatment of patients with locally advanced or metastatic, non-squamous NSCLC whose disease has not progressed after four cycles of platinum-based first-line chemotherapy.
- As a single agent for the treatment of patients with recurrent, metastatic non-squamous, NSCLC after prior chemotherapy.
  Limitations of Use: Alimta and Pemfexy are not indicated for the treatment of patients with squamous cell, non-small cell lung cancer.
- Initial treatment, in combination with cisplatin, of patients with malignant pleural mesothelioma whose disease is unresectable or who are otherwise not candidates for curative surgery.

Policy/Criteria

Prior authorization is required. Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections 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 per m^2 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: 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*).***

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

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).***

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

Approval duration: 6 months

D. Primary Central Nervous System Lymphoma (off-label) (must meet all):
1. **Diagnosis of primary central nervous system lymphoma;**
2. **Prescribed by or in consultation with an oncologist or hematologist;**
3. **Age ≥ 18 years;**
4. **Pemetrexed is prescribed for one of the following (a or b):**
   a. **Relapsed or refractory disease;**
   b. **Induction therapy as a single agent if member is unsuitable for or intolerant to high-dose methotrexate;**
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: 6 months

E. Other diagnoses/indications

1. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.**

II. Continued Therapy

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

1. **Currently receiving medication via Louisiana Healthcare Connections benefit or documentation supports that member has received Alimta or Pemfexy 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^2 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: 12 months

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

1. **Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.**
   Approval duration: Duration of request or 6 months (whichever is less); or
2. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.**

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 – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALK: anaplastic lymphoma kinase
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s): history of severe hypersensitivity reaction to pemetrexed**
- **Boxed warning(s): none reported**

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	500 mg/m^2 IV 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^2 IV infusion every 21 days
Malignant pleural mesothelioma	500 mg/m^2 IV on Day 1 of each 21-day cycle in combination with cisplatin	

VI. Product Availability

Single-dose vial for injection: 100 mg (Alimta), 500 mg (Alimta, Pemfexy)

VII. References

1. Alimta Prescribing Information. Indianapolis, IN: Eli Lilly Pharmaceuticals; January 2019. Available at: www.alimta.com. Accessed November 6, 2020.
2. Pemfexy Prescribing Information. Woodcliff Lake, NJ: Eagle Pharmaceuticals, Inc. February 2020. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/209472s000lbl.pdf. Accessed November 6, , 2020.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed November 6, 2020.
4. Non-Small Cell Lung Cancer Version 8.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2020.
5. Malignant Pleural Mesothelioma Version 2.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 6, 2020.

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
Converted corporate to local policy	03.2021

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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