

Clinical Policy: Pemetrexed (Alimta)

Reference Number: CP.PHAR.368

Effective Date: 10.31.17

Last Review Date: 02.19

Line of Business: HIM-Medical Benefit, 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:

- Treatment of locally advanced or metastatic nonsquamous non-small cell lung cancer (NSCLC):
 - In combination with cisplatin as initial treatment
 - 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
 - As a single agent as maintenance treatment for disease that has not progressed after four cycles of platinum-based first-line chemotherapy
 - 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.

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.

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 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 m² 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 \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*).

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 \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*).

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 or hematologist;
3. Age \geq 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 \geq 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

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1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

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 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/m² 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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

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 policies – CP.PMN.53 for Medicaid and HIM-Medical Benefit.

IV. Appendices/General Information*Appendix A: Abbreviation/Acronym Key*

ALK: anaplastic lymphoma kinase

EGFR: epidermal growth factor receptor

FDA: Food and Drug Administration

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

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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, 500 mg

VII. References

1. Alimta Prescribing Information. Indianapolis, IN: Eli Lilly Pharmaceuticals; January 2019. Available at: www.alimta.com. Accessed February 13, 2019.
2. Non-small cell lung cancer (Version 3.2019). National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed February 13, 2019.
3. Malignant pleural mesothelioma (Version 2.2018). National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed October 8, 2018
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 13, 2019.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed October 8, 2018.

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
1Q 2019 annual review; HIM-Medical Benefit line of business added; age added; new NSCLC labeled indication added to indication section; bladder cancer relabeled as UC, methotrexate trial removed from CNS lymphoma and FDA approved treatments removed from ovarian cancer to encompass NCCN uses; references reviewed and updated.	11.13.18	02.19
No significant changes; added updated FDA indication: NSCLC without EGFR or ALK gene mutation in combination with platinum	03.14.19	

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
chemotherapy and pembrolizumab; this is already a covered use, therefore no modification to criteria was required; references reviewed and updated.		

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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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