Drugs Therapy Guidelines

Alimta® (pemetrexed)

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<tr>
<th>Medical Benefit</th>
<th>Applicable</th>
<th>Effective: 5/1/18</th>
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<tr>
<td>Pharmacy-Formulary 1</td>
<td>x</td>
<td>Next Review: 3/19</td>
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<td>Pharmacy-Formulary 2</td>
<td>Date of Origin: 1/1/16</td>
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I. Medication Description

Alimta (pemetrexed) is a pyrimidine-based antifolate that suppresses tumor growth by inhibiting both DNA synthesis and folate metabolism at multiple target enzymes. This multiple enzyme inhibition is unique, as methotrexate inhibits only dihydrofolate reductase, and 5-fluorouracil and raltitrexed inhibit only thymidine synthetase. Thus, Alimta may be useful for 5-fluorouracil-, methotrexate-, and raltitrexed-resistant cancers. Folic acid and vitamin B12 supplementation is needed to reduce hematologic and gastrointestinal toxicity and enable therapy continuation; dexamethasone is also required to mitigate cutaneous toxicity.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Alimta is available when the following criteria have been met:

- Member is at least 18 years of age AND
- The medication is prescribed by a hematologist/oncologist AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage is available for FDA-approved and/or NCCN Guidelines-supported dosing regimens, dependent upon diagnosis and body surface area.

V. Coverage Duration

Coverage is approved for up to 6 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:
Drug Therapy Guidelines

Alimta® (pemetrexed)

Last Review Date: 3/2018

- Stabilization of disease or in absence of disease progression AND
- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

- Available as 100 mg and 500 mg single-dose vials for injection
- J9305 – 1 billable unit is 10mg
- Pertinent indications:
  - Bladder cancer: C61, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0-C67.9, C68.0, D09.0, Z85.51, Z85.59
  - CNS cancer: C83.30, C83.31, C83.39, C83.80, C83.81, C83.89
  - Mesothelioma: C38.4, C45.0, C45.1
  - NSCLC: C33, C34.00-C34.02, C34.10-C34.12, C34.2, C34.30-C34.32, C34.80-C34.82, C34.90-C34.92, Z85.118
  - Ovarian cancer: C48.1, C48.2, C48.8, C56.1, C56.2, C56.9, C57.00-C57.02, C57.10-C57.12, C57.20-C57.22, C57.3, C57.4, C57.7-C57.9, Z85.43
  - Thymomas and Thymic Carcinomas: C37, D15.0

VIII. Summary of Policy Changes

- 1/1/16: new policy
- 3/15/16: no policy changes
- 4/5/17: no policy changes
- 5/1/18: coverage criteria updated to allow use as supported by current NCCN guidelines

IX. References

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.