POLICY NUMBER UM ONC_1130	**SUBJECT** Alimta™ (pemetrexed)		**DEPT/PROGRAM** UM Dept.	**PAGE 1 OF 2**
DATES COMMITTEE REVIEWED 07/22/11, 01/02/13, 03/13/13, 02/12/14, 12/16/15, 06/22/16, 04/04/17, 04/12/17, 04/11/18, 04/10/19, 12/11/19, 12/19/20, 03/11/20, 06/10/20	**APPROVAL DATE** June 10, 2020	**EFFECTIVE DATE** June 26, 2020	**COMMITTEE APPROVAL DATES** (latest version listed last) 07/22/11, 01/02/13, 03/13/13, 02/12/14, 12/16/15, 06/22/16, 04/04/17, 04/12/17, 04/11/18, 04/10/19, 12/11/19, 03/11/20, 06/10/20	
PRIMARY BUSINESS OWNER: UM **APPROVED BY:** Dr. Andrew Hertler		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee		
URAC STANDARDS HUM 1		**NCQA STANDARDS** UM 2	**ADDITIONAL AREAS OF IMPACT**	
CMS REQUIREMENTS	**STATE/FEDERAL REQUIREMENTS**		**APPLICABLE LINES OF BUSINESS** All	

I. PURPOSE

To define and describe the accepted indications for Alimta (pemetrexed) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century is responsible for processing all medication requests from network ordering providers. Medications not authorized by New Century may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

1. **PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:**
    a. When health plan Medicaid coverage provisions- including any applicable PDLs (Preferred Drug Lists)- conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the **Preferred Drug Guidelines OR**
    b. When health plan Exchange coverage provisions- including any applicable PDLs (Preferred Drug Lists)- conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the **Preferred Drug Guidelines OR**
    c. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the **Preferred Drug Guidelines shall follow NCH L1 Pathways** when applicable, otherwise shall follow NCH drug policies **AND**
    d. Continuation requests of previously approved non-preferred medication are not subject to this provision **AND**
    e. When available, generic alternatives are preferred over brand-name drugs.
2. **Non-Small Cell Lung Cancer (NSCLC)**
    a. The member has recurrent or metastatic non-squamous NSCLC and Alimta (pemetrexed) may be used for **ANY** of the following:
        i. First line therapy for EGFR, ALK, ROS1, and other driver mutation negative disease in combination with carboplatin/cisplatin and pembrolizumab **OR**
        ii. First line therapy for EGFR, ALK, ROS-1, and other driver mutation negative disease in combination with carboplatin/cisplatin **OR**

iii. Subsequent therapy for EGFR/ALK/ROS1 positive disease- in members that have received targeted therapies for any of the above 3 genomic alterations- either as a single agent, or in combination with carboplatin/cisplatin **OR**

iv. Subsequent therapy as a single agent **OR**

v. Continuation maintenance therapy in combination with pembrolizumab following first-line therapy with pembrolizumab, pemetrexed and either cisplatin or carboplatin.

3. **Mesothelioma**

a. The member has malignant pleural mesothelioma and Alimta (pemetrexed) may be used in **ONE** of the following:

i. In combination with cisplatin/carboplatin for stage I-IIIA clinically operable disease **OR**

ii. As first line therapy for unresectable or metastatic disease as a single agent or in combination with cisplatin or carboplatin **OR**

iii. As subsequent therapy as a single agent.

III. EXCLUSION CRITERIA

1. Off-label indications for Alimta (pemetrexed) in bladder and ovarian cancers shall be reviewed for appropriateness per National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or other compelling medical literature publications.
2. For member with NSCLC, Alimta (pemetrexed) will be used for any of the following:
   a. Squamous cell histology
   b. As adjuvant therapy for stage IA
3. Dosing exceeds single dose limit of Alimta (pemetrexed) 500 mg/m^2.
4. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT

Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

1. Review – Utilization Management Department
2. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

None

VII. REFERENCES

1. Alimta (pemetrexed) prescribing information. Eli Lilly and Company. Indianapolis, IN 2019.
2. Clinical Pharmacology Elsevier Gold Standard 2020.
3. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, CO 2020.
4. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2020.
5. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs . Bethesda, MD 2020.