

## Clinical Policy: Pralatrexate (Folotyn)

Reference Number: LA.PHAR.313

Effective Date: 11.04.23

Last Review Date: 04.22.24

Line of Business: Medicaid

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**\*\*Please note: This policy is for medical benefit\*\***

### Description

Pralatrexate injection (Folotyn®) is a folate analog metabolic inhibitor.

### FDA Approved Indication(s)

Folotyn is indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL).

This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

### 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 Louisiana Healthcare Connections that Folotyn is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Peripheral T-Cell Lymphoma (must meet all):

1. Diagnosis of PTCL (*see Appendix D for examples of PTCL subtypes*);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. One of the following (a or b):
  - a. Prescribed as initial palliative intent therapy;
  - b. Failure of at least one prior therapy (*see Appendix B for examples*);\*  
*\*Prior authorization may be required for prior therapies*
5. Prescribed as a single-agent therapy;
6. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 30 mg/m<sup>2</sup> once weekly for 6 weeks in 7-week cycles;
  - 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. NCCN-Recommended Off-Label Indications** (must meet all):

1. Diagnosis of one of the following conditions (a or b):
  - a. Primary cutaneous T-cell lymphomas (i or ii):
    - i. Mycosis fungoides or Sézary syndrome;
    - ii. Primary cutaneous anaplastic large cell lymphoma (ALCL) with multifocal lesions, or cutaneous ALCL with regional nodes;
  - b. Other T-cell lymphomas (i, ii, iii, or iv):
    - i. Adult T-cell leukemia/lymphoma (ATLL) after failure of first-line therapy (*see Appendix B for examples*);
    - ii. Extranodal NK/T-cell lymphoma (NKTL) following asparaginase-based therapy (*see Appendix B for examples*);
    - iii. Hepatosplenic gamma-delta T-cell lymphoma (HGTL) after failure of 2 prior treatment regimens (*see Appendix B for examples*);
    - iv. Breast implant-associated anaplastic large cell lymphoma (BI-ALCL) after failure of first-line therapy (*see Appendix B for examples*);
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*).

*\*Prior authorization may be required for prior line therapies*

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

**Approval duration: 6 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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 is currently receiving Folutyn 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 30 mg/m<sup>2</sup> once weekly for 6 weeks in 7-week cycles;
  - 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. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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*

|   |   |
|---|---|
| ALCL: anaplastic large cell lymphoma                              | HGTL: hepatosplenic gamma-delta T-cell lymphoma |
| ATLL: adult T-cell leukemia/lymphoma                              | NCCN: National Comprehensive Cancer Network     |
| BI-ALCL: breast implant-associated anaplastic large cell lymphoma | NKTL: extranodal NK/T-cell lymphoma             |
| FDA: Food and Drug Administration                                 | PTCL: peripheral T-cell lymphoma                |

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

| <b>Drug Name</b>  | <b>Dosing Regimen</b> | <b>Dose Limit/Maximum Dose</b> |
|---|-----------------------|--------------------------------|
| PTCL - examples of first-line and subsequent therapy: <ul style="list-style-type: none"> <li>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)</li> <li>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)</li> <li>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)</li> <li>• Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)</li> <li>• DHAP (dexamethasone, cisplatin, cytarabine)</li> <li>• ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin)</li> <li>• Belinostat, brentuximab vedotin, romidepsin as single agents</li> </ul> | Varies                | Varies                         |
| ATLL - examples of first-line therapy: <ul style="list-style-type: none"> <li>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)</li> <li>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)</li> <li>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)</li> <li>• Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)</li> <li>• HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine</li> </ul>   | Varies                | Varies                         |
| NKTL - examples of asparaginase-based therapy: <ul style="list-style-type: none"> <li>• AspaMetDex (pegaspargase, methotrexate, dexamethasone)</li> </ul>   | Varies                | Varies                         |

| Drug Name   | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|----------------|--------------------------|
| <ul style="list-style-type: none"> <li>• DDGP (dexamethasone, cisplatin, gemcitabine, pegaspargase)</li> <li>• Modified-SMILE (steroid, methorexate, ifosfamide, pegaspargase, etoposide)</li> <li>• P-GEMOX (gemcitabine, pegaspargase, oxaliplatin)</li> </ul>  |                |                          |
| HGTL - examples of first-line therapy (for subsequent therapy examples see PTCL): <ul style="list-style-type: none"> <li>• ICE (ifosfamide, carboplatin, etoposide)</li> <li>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)</li> <li>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)</li> </ul>  | Varies         | Varies                   |
| BI-ALCL - examples of first-line therapy: <ul style="list-style-type: none"> <li>• Brentuximab vedotin</li> <li>• Brentuximab vedotin + CHP (cyclophosphamide, doxorubicin, and prednisone)</li> <li>• CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)</li> <li>• CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone)</li> <li>• Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)</li> </ul> | Varies         | Varies                   |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: PTCL Subtypes/Histologies\**

- PTCL, not otherwise specified
- Anaplastic large cell lymphoma
- Angioimmunoblastic T-cell lymphoma
- Enteropathy-associated T-cell lymphoma
- Monomorphic epitheliotropic intestinal T-cell lymphoma
- Nodal peripheral T-cell lymphoma with TFH phenotype
- Follicular T-cell lymphoma

*\*PTCL is classified as a non-Hodgkin T-cell lymphoma. PTCL classification schemes are periodically advanced as new information becomes available; therefore, the above list is provided as general guidance. For additional information, see WHO's 2016 updated classification of hematological malignancies for a complete list of lymphoid neoplasms, including PTCL.*

**V. Dosage and Administration**

| Indication | Dosing Regimen  | Maximum Dose                     |
|------------|---|----------------------------------|
| PTCL       | 30 mg/m <sup>2</sup> IV once weekly for 6 weeks in 7-week cycles until progressive disease or unacceptable toxicity | 30 mg/m <sup>2</sup> once weekly |

**VI. Product Availability**

Single-dose vial: 20 mg/1 mL, 40 mg/2 mL

**VII. References**

1. Folutyn Prescribing Information. East Windsor, NJ: Acrotech Biopharma LLC; September 2020. Available at: <https://www.folutyn.com/hcp/wp-content/uploads/2019/11/Folutyn-PI-09-2020-REF-0255.pdf>. Accessed June 30, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at [nccn.org](http://nccn.org). Accessed July 10, 2023.
3. National Comprehensive Cancer Network. T-Cell Lymphomas Version 1.2023. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/t-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf). Accessed July 10, 2023.

**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                   |
|-------------|-------------------------------|
| J9307       | Injection, pralatrexate, 1 mg |

| Reviews, Revisions, and Approvals                                       | Date     | LDH Approval Date |
|---|----------|-------------------|
| Converted corporate to local policy.                                    | 06.15.23 | 10.05.23          |
| Annual review: no significant changes; references reviewed and updated. | 04.22.24 |                   |

**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.

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