VENTURA COUNTY
HEALTH CARE PLAN

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable) – Pralatrexate Products Utilization Management Medical Policy
- Folotyn® (pralatrexate intravenous infusion – Spectrum, generic)

REVIEW DATE: 06/18/2025

OVERVIEW

Folotyn, a dihydrofolate reductase inhibitor, is indicated for the treatment of relapsed or refractory **peripheral T-cell lymphoma**.[1] This indication is based on overall response rate. Continued approval for this indication may be contingent on verification and description of clinical benefit in a confirmatory trial.

Guidelines

Pralatrexate is addressed in National Comprehensive Cancer Network (NCCN) guidelines:

- **Primary Cutaneous Lymphomas:** The NCCN clinical practice guidelines (version 2.2025 – April 1, 2025) recommend pralatrexate as systemic therapy for mycosis fungoides/Sezary syndrome with or without skin-directed therapy and as a single agent for primary cutaneous CD30+ T-cell lymphoproliferative disorders.[2,3] In addition, NCCN recommends therapy for subcutaneous Panniculitis-Like T-Cell lymphoma with hemophagocytic lymphohistiocytosis, systemic disease or high tumor burden. NCCN also recommends therapy for subcutaneous Panniculitis-Like T-Cell lymphoma without hemophagocytic lymphohistiocytosis and with low tumor burden (category 2A).
- **T-Cell Lymphomas:** The NCCN clinical practice guidelines (version 2.2025 – May 28, 2025) recommend pralatrexate as a single agent for the second-line or subsequent therapy of relapsed or refractory peripheral T-cell lymphomas including anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, and nodal peripheral T-cell lymphoma with T-follicular helper phenotype; breast implant-associated anaplastic large cell lymphoma; adult T-cell leukemia/lymphoma; extranodal NK/T-cell lymphoma; and hepatosplenic T-cell lymphoma.[3,4]

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of pralatrexate. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with pralatrexate as well as the monitoring required for adverse events and long-term efficacy, approval requires pralatrexate to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of pralatrexate is recommended in those who meet one of the following criteria:

FDA-Approved Indication

1. **T-Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   Note: Examples of peripheral T-cell lymphoma include anaplastic large cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, angioimmunoblastic T-cell lymphoma, peripheral T-cell lymphoma not otherwise specified.
   A) Patient is ≥ 18 years of age; AND
   B) Patient has peripheral disease; AND
   C) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle.

Other Uses with Supportive Evidence

2. **Adult T-Cell Leukemia/Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has chronic high risk, acute, or lymphoma subtype; AND
   C) The medication is used as second-line or subsequent therapy; AND
   D) The medication is used as a single agent; AND
   E) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle.

3. **Breast Implant-Associated Anaplastic Large Cell Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed or refractory disease; AND
   C) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle.

4. **Cutaneous CD30+ T-Cell Lymphoproliferative Disorders.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has ONE of the following diagnoses (i or ii):
      i. Primary cutaneous anaplastic large cell lymphoma with multifocal lesions; OR
      ii. Cutaneous anaplastic large cell lymphoma with regional nodes; AND
   C) The medication is used as a single agent; AND
   D) The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve ONE of the following (A or B):
   A) Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle; OR
   B) Approve 15 mg/m^2 administered intravenously once weekly for 3 weeks in each 4 week cycle.

5. Extranodal NK/T-Cell Lymphoma. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
- **A)** Patient is ≥ 18 years of age; AND
- **B)** Patient has relapsed/refractory disease; AND
- **C)** The medication is used as a single agent; AND
- **D)** The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle.

6. Hepatosplenic T-Cell Lymphoma. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
- **A)** Patient is ≥ 18 years of age; AND
- **B)** The medication is used as subsequent therapy after two systemic regimens; AND
  Note: Examples of systemic regimens include ICE (ifosfamide, carboplatin, etoposide), DHAP (dexamethasone, cytarabine, cisplatin), DHAX (dexamethasone, cytarabine, oxaliplatin), IVAC (ifosfamide, etoposide, cytarabine).
- **C)** The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle.

7. Mycosis Fungoides/Sezary Syndrome. Approve for 1 year if the patient meets BOTH of the following (A and B):
- **A)** Patient is ≥ 18 years of age; AND
- **B)** The medication is prescribed by or in consultation with an oncologist or dermatologist.

Dosing. Approve ONE of the following (A or B):
- **A)** Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle; OR
- **B)** Approve 15 mg/m^2 administered intravenously once weekly for 3 weeks in each 4 week cycle.

8. Subcutaneous Panniculitis-Like T-Cell Lymphoma. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
- **A)** Patient is ≥ 18 years of age; AND
- **B)** Patient meets ONE of the following (i or ii):
  - **i.** Patient has hemophagocytic lymphohistiocytosis, systemic disease or high tumor burden; OR
  - **ii.** Patient meets BOTH of the following (a and b):
    - **a)** Patient has low tumor burden without hemophagocytic lymphohistiocytosis; AND
    - **b)** Medication is used as subsequent therapy; AND
- **C)** The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve up to 30 mg/m^2 administered intravenously once weekly for 6 weeks in each 7 week cycle.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of pralatrexate is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Folotyn® injection [prescribing information]. East Windsor, NJ: Acrotech Biopharma; October 2020.
2. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (version 2.2025 – April 1, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 22, 2025.
3. The NCCN Drugs and Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 22, 2025. Search term: pralatrexate.
4. The NCCN T-Cell Lymphomas Clinical Practice Guidelines in Oncology (version 2.2025 – May 28, 2025. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on April 22, 2025.
5. Horwitz SM, Kim YH, Foss F, et al. Identification of an active, well-tolerated dose of pralatrexate in patients with relapsed or refractory cutaneous T-cell lymphoma. *Blood*. 2012;119(18):4115-4122.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Cutaneous CD30+ T-Cell Lymphoproliferative Disorders:** Added 15 mg/m^2 administered intravenously once weekly for 3 weeks in each 4 week cycle dosing regimen. **Mycosis Fungoides/Sezary Syndrome:** Added 15 mg/m^2 administered intravenously once weekly for 3 weeks in each 4 week cycle dosing regimen.	05/31/2023
Annual Revision	No criteria changes.	06/05/2024
Annual Revision	**T-Cell Lymphoma:** Removed the requirements that patient has relapsed or refractory disease and the medication is used as a single agent. **Adult T-Cell Leukemia/Lymphoma:** Added chronic high risk as a requirement for approval. **Breast Implant-Associated Anaplastic Large Cell Lymphoma:** Removed the requirement that the medication is used as a single agent. **Extranodal NK/T-Cell Lymphoma:** Removed the requirement following combination asparaginase-based chemotherapy. **Hepatosplenic T-Cell Lymphoma:** Removed the requirement that the medication is used as second line or subsequent therapy and added the medication is used as subsequent therapy after two systemic regimens. Removed the requirement that the medication is used as a single agent. **Subcutaneous Panniculitis-Like T-Cell Lymphoma:** Added Subcutaneous Panniculitis-Like T-Cell Lymphoma as a new condition for approval.	06/18/2025