Reference number(s)
1702-A

SPECIALTY GUIDELINE MANAGEMENT

FOLOTYN (pralatrexate)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications[1]
Treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL)

B. Compendial Uses[2]
1. Adult T-cell leukemia/lymphoma (ATLL)
2. Mycosis fungoides/Sezary syndrome (MF/SS)
3. Primary cutaneous CD30+ T-cell lymphoproliferative disorders

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Peripheral T-cell lymphoma (PTCL)[1,2]
Authorization of 12 months may be granted for treatment of PTCL.

B. Adult T-cell leukemia/lymphoma (ATLL)[2]
Authorization of 12 months may be granted for treatment of ATLL.

C. Mycosis fungoides/Sezary syndrome (MF/SS)[2]
Authorization of 12 months may be granted for treatment of MF or SS.

D. Primary cutaneous CD30+ T-cell lymphoproliferative disorders[2]
Authorization of 12 months may be granted for treatment of cutaneous anaplastic large cell lymphoma (ALCL).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Folotyn [package insert]. Westminster, CO: Allos Therapeutics, Inc.; May 2016.
2. The NCCN Drugs & Biologics Compendium® © 2018 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 28, 2018.