Pharmacy Policy

Antiemetics

Policy Number: 9.905
Revision Number: R0
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☒ New Hampshire Medicaid	☐ MassHealth - MCO ☐ MassHealth - ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Akynzeo (netupitant and palonosetron) oral [QL] and IV[NP, QL]**
- **Anzemet (dolasetron) tablet[NP QL]**
- **aprepitant (Emend) oral [QL]**
- **Cinvanti (aprepitant) IV[NP QL]**
- **Diclegis[NP QL]**
- **Doxylamine succ/pyridoxine HCL [QL]**
- **dronabinol (Marinol) oral [QL]**
- **Emend[NP, QL]**
- **granisetron tablet [QL]**
- **ondansetron (Zofran) oral (requires PA when quantity exceeds quantity limitation)**
- **palonosetron (Aloxi) IV**
- **Sancuso[NP QL]**
- **Sustol[NP QL]**
- **Varubi (rolapitant) oral[NP, QL]Zofran/ODT/soln[NP QL]**
- **Zuplenz[NP, QL]**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered	All FDA approved indications not otherwise excluded

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Use	
Required Medical Information	**Akynzeo, Anzemet, Cinvanti, Diclegis, Emend, Sancuso, Sustol, Varubi, Zofran/ODT/soln, Zuplenz** **1.** A trial and failure of 2 Preferred products required prior to Non-Preferred products (See Appendix A) **dronabinol* (Marinol) oral capsules** Documentation of the following: 1. A diagnosis of CINV; **AND** a) An inadequate response, contraindication or intolerance to an emetic regimen that includes of a combination of a serotonin antagonist, dexamethasone and a neurokinin receptor antagonist (Emend®); **OR** 2. A diagnosis of AIDS related anorexia **palonosetron (Aloxi) IV:** Documentation of the following: **1.** An indication of the chemotherapy induced nausea and vomiting (CINV) due to moderate to high emetogenic potential chemotherapy. **<u>Quantity Limitation Override:</u>** **All antiemetics** 1. A daily dose of the requested medication that cannot be achieved with commercially available dosage strengths and forms is required; **OR** 2. Need for a dosage frequency greater than what is recommended by the FDA and documentation of the supporting rationale for the prescribed frequency; **OR** 3. Dosage titration (up to 3 months) cannot be achieved with commercially available dosage strengths and forms. **Ondansetron for Non-CINV (including hyperemesis gravidarum)** The Plan will approve prescriptions for ondansetron up to three times daily for treatment of nausea and vomiting not related to chemotherapy, when the following criteria are met: 1. An inadequate response or intolerance to two of the following three medication treatment options: • Antihistamine therapy (meclizine, hydroxyzine, doxylamine, diphenhydramine, or dimenhydrinate) • Phenothiazine therapy (promethazine or prochlorperazine) • Metoclopramide; AND **In addition, for hyperemesis gravidarum:** **2.** An anticipated delivery date.

Coverage Duration	Initial: up to 12 months For hyperemesis gravidarum: maximum of 90 days, or up to the due date whichever is earlier
Quantity Limit	See Appendix B

Appendix A – PDL Preferred and Non-Preferred Agents

ANTIEMETICS	
PREFERRED	**NON-PREFERRED**
• aprepitant/ pack (generic for Emend®/pack) • doxylamine succ/pyridoxine HCL (generic for Diclegis®) • granisetron tab (generic for Kytril®) • ondansetron (generic for Zofran®)	• Akynzeo® • Anzemet® • Cinvanti® • Diclegis® • Emend®/pack • Sancuso® • Sustol® • Varubi® • Zofran®/ODT/soln • Zuplenz®

Appendix B – Quantity Limitations for Antiemetics

Medication Name and Strength	Maximum Quantity
Akynzeo 300 mg/0.5 mg capsule	4 per 30 days
Anzemet	10 per 30 days
aprepitant/Emend 40mg capsules	1 per 30 days
aprepitant/Emend 80mg capsules	8 per 30 days
aprepitant/Emend 125mg capsules	4 per 30 days
aprepitant Pak (1 x125mg capsules and 2x80mg capsules)	12 capsules (4 paks) per 30 days
Cinvanti	18mL per treatment
Diclegis	120 per 30 days
doxylamine succ/pyridoxine HCL	120 per 30 days
dronabinol 2.5 mg, 5 mg, 10 mg capsules	60 per 30 days
Emend Suspension	15 per 30 days
granisetron tab	10 per 30 days
ondansetron 24mg tablet	5 per 30 days
ondansetron/Zofran 4 mg, 8 mg ODT	30 per 30 days
ondansetron/Zofran 4 mg/5 mL oral solution	150 mL per 30 days
Sancuso	4 patches per 28 days
Sustol	4 syringes per 28 days
Varubi™ 90 mg tablet	8 per 30 days
Zuplenz	10 per 7 days

Applicable Coding:

Code	Medication
J1453	Emend (fosaprepitant)
C9463	Cinvanti (aprepitant)
J1626	granisetron
J1627	granisetron extended-release/Sustol
J2469	palonesetron (Aloxi)
J1454	Akynzeo for injection

Clinical Background Information and References

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Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	9.104 Antiemetics Policy retired, new policy created	1/1/2021	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.