BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Antiemetics

Policy Number: 9.905
Version Number: 2.0
Version Effective Date: 3/1/2022

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☐ 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**
- **Cinvanti (aprepitant) IV[NF]**
- **palonsetron IV**
- **Varubi (rolapitant) oral**

NF: Non-formulary

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

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	None
Required Medical	**Akynzeo® (netupitant and palonosetron) oral, Cinvanti (aprepitant) IV[NF], Varubi®(rolapitant) oral**: 1. Treatment with chemotherapy which has high emetogenic potential as defined by ASCO; **OR**

[+] *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.

Information	2. Treatment with a chemotherapy regimen which includes an anthracycline and cyclophosphamide in combination; **OR** 3. Treatment with a moderately emetogenic chemotherapy regimen as defined by ASCO; ***AND one of the following:*** a. Chemotherapy regimen includes carboplatin AUC ≥ 4mg/ml/min; ***OR*** b. An inadequate response or contraindication to a trial of a serotonin antagonist (e.g. ondansetron, or palonosetron [requires PA]) used in combination with dexamethasone. **palonosetron (Aloxi) IV:** 1. An indication of the chemotherapy induced nausea and vomiting (CINV) due to moderate to high emetogenic potential chemotherapy.
Coverage Duration	12 month

Applicable Coding:

Code	Medication
C9463	**Cinvanti (aprepitant)**
J2469	**palonesetron (Aloxi)**

Clinical Background Information and References

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3. Funai, Edmund. Hyperemesis gravidarum. Up To Date Online, accessed 10/13/2013.
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12. Niebyl JR. Nausea and vomiting in pregnancy. NEJM. 2010;363:1544-1550.
13. Prescribing Information: Zuplenz®, ondansetron oral soluble film. Par Pharmaceutical, Inc. Woodcliff Lake, NJ. Accessed October 13, 2013. Available at: http://www.zuplenz.com/.
14. Product Information: Sancuso®, granisetron transdermal system. ProStraken, Inc. Bedminster, NJ: August, 2008; accessed 10/13/2013
15. Product Information: Akynzeo®, netupitant/palonsetron. Eisai, Inc. Woodcliff, NJ: October, 2014. Accessed 4 November 2014. Available at: http://www.akynzeo.com.
16. Product Information: Cesamet®, nabilone. Valeant Pharmaceuticals, Intl., Costa Mesa, CA. May 2006.
17. Product Information: Diclegis®. Duchesnay, Inc, Bryn Mawr, PA. Accessed October 29, 2013.
18. Product Information: Emend®(aprepitant). Merck Sharp & Dohme Corp., a subsidiary of MERCK & CO., INC., Whitehouse Station, NJ: December 2015. Accessed 10 October, 2016
19. Product Information: Marinol®, dronabinol. Solvay Pharmaceuticals, Inc., Marietta, GA, 2006.
20. Product Information: Sustol® (granisetron) extended release injection. HERON THERAPEUTICS, Redwood City, CA, 94063: August 2016. Accessed 12 October, 2016.
21. Product Information: Varubi™. Rolapitant. TESARO, Inc, Waltham, MA: September, 2015. Accessed 18 October 2015. Available at: http://varubirx.com/.
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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

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
1/14/2021	Updated policy to include non-formulary product Cinvanti IV.	1/14/2021	P&T Committee
11/11/2021	P&T Annual Review. Remove Akynzeo IV (already NF). Remove QL criteria/section.	3/1/2022	P&T Committee

Next Review Date

11/2022

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.