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	**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 capsule** (netupitant and palonosetron)
- **Akynezo IV** (fosnetupitant and palonosetron)
- **aprepitant capsule**
- **Cinvanti IV** (aprepitant)
- **dronabinol capsule**
- **Emend oral suspension** (aprepitant)
- **fosaprepitant IV**
- **granisetron tablet**
- **ondansetron tablet/ODT/oral solution *over quantity limit*** (requests within the quantity limit do not require PA)
- **palonosetron IV**
- **Varubi tablet** (rolapitant)

[+] *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.

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 Information	**granisetron tablet:** 1. An indication of chemotherapy-induced nausea and vomiting (CINV) due to moderate to high emetogenic potential chemotherapy; **AND** 2. An inadequate response to a trial of ondansetron. **Akynzeooral and IV, aprepitantoral, Cinvanti IV, Emend oral suspension, fosaprepitant IV, Varubi tablet**: 1. One of the following: a. Treatment with chemotherapy which has high emetogenic potential as defined by ASCO; **OR** b. Treatment with a chemotherapy regimen which includes an anthracycline and cyclophosphamide in combination; **OR** c. Treatment with a moderately emetogenic chemotherapy regimen as defined by ASCO; ***AND one of the following:*** i. Chemotherapy regimen includes carboplatin AUC ≥ 4mg/ml/min; ***OR*** ii. An inadequate response or contraindication to a trial of a serotonin antagonist (e.g. ondansetron, or palonosetron [requires PA]) used in combination with dexamethasone; ***AND*** 2. For Emend oral suspension, the member has swallowing difficulties due to a clinical condition **dronabinol capsule** 1. A diagnosis of chemotherapy-induced nausea and vomiting (CINV); **AND** a. An inadequate response, contraindication, or intolerance to an emetic regimen that includes a combination of a serotonin antagonist, dexamethasone, and a neurokinin receptor antagonist (such as aprepitant or fosapreptinant); **OR** 2. A diagnosis of AIDS related anorexia **palonosetron IV:** 1. An indication of the chemotherapy-induced nausea and vomiting (CINV) due to moderate to high emetogenic potential chemotherapy. **Ondansetron Requests Over Quantity Limit** (see appendix A) **Ondansetron for chemotherapy-induced nausea and vomiting (CINV):** 1. A daily dose of ondansetron that cannot be achieved with commercially available dosage strengths and forms is required or the requested dosage frequency is greater than what is recommended by the FDA or covered by the plan; ***AND*** a. Member is tolerating ondansetron at a lower dose without experiencing adverse effects or clinical rationale why member has not tried ondansetron at lower dose; **AND**

	b. Member had an inadequate response to ondansetron at a lower dosage and the inadequate response is not due to medication non-adherence. **AND** c. Documentation is provided that includes supporting rationale for the use of ondansetron at the requested dose utilizing current guidelines, drug compendia and/or clinical trials; ***OR*** 2. Dosage titration (up to 3 months) cannot be achieved with commercially available dosage strengths and forms. **Ondansetron for nausea and vomiting not related to chemotherapy:** The Plan will approve prescriptions for ondansetron up to three times daily for 30 days (90 tablets per 30 days) for the 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: a. Antihistamine therapy (meclizine, hydroxyzine, doxylamine, diphenhydramine, or dimenhydrinate) b. Phenothiazine therapy (promethazine or prochlorperazine) c. Metoclopramide; AND 2. If the diagnosis is hyperemesis gravidarum, an anticipated delivery date is provided
Coverage Duration	Ondanestron for hyperemesis gravidarum: maximum of 90 days, or up to the due date whichever is earlier All other requests: 12 months

Applicable Coding:

Code	Medication
J1453	**fosaprepitant (Emend)**
C9463	**Cinvanti (aprepitant)**
J1626	**granisetron**
J2469	**palonesetron (Aloxi)**
J1454	**Akynzeo for injection**

Clinical Background Information and References

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Appendix A – Quantity Limitations for Antiemetics

Medication Name and Strength	Maximum Quantity
Akynzeo® 300 mg/0.5 mg capsule	4 per 30 days
Dronabinol 2.5 mg, 5 mg, 10 mg capsules	60 per 30 days
aprepitant 40mg capsules	1 per 30 days
aprepitant 80mg capsules	8 per 30 days
aprepitant 125mg capsules	4 per 30 days
aprepitant Pak (1 x125mg capsules and 2x80mg capsules)	12 capsules (4 paks) per 30 days
ondansetron 4mg, 8mg tablets	21 *per fill*
ondansetron 24mg tablet	5 per 30 days
ondansetron 4 mg, 8 mg ODT	21 *per fill*
ondansetron 4 mg/5 mL oral solution	100 mL per 30 days
Varubi™ 90 mg tablet	8 per 30 days

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
11/14/2018	P&T Annual review: no changes	03/03/2020	P&T Committee
12/1/2020	9.104 Antiemetics Policy retired, new policy created	1/1/2021	P&T Committee
11/11/2021	P&T Annual Review. Removed discontinued products. Replace Emend IV with fosaprepitant. Change QL section to only apply to ondansetron and update language to match current QL policy. Update quantity limits.	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.