# Medical Policy

**Healthcare Services Department**

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|---|---|---|
| Oral antiemetic drugs: Aprepitant | MP-RX-FP-07-23 | ☒ MMM MA ☒ MMM Multihealth |

## Service Category

☐ Anesthesia
☐ Surgery
☐ Radiology Procedures
☐ Pathology and Laboratory Procedures
☐ Medicine Services and Procedures
☐ Evaluation and Management Services
☐ DME/Prosthetics or Supplies
☒ Part B Drugs

## Service Description

This document addresses the use of *Oral Antiemetics (Aprepitant)* , a substance P/neurokinin 1 (NK1) receptor antagonist, approved by the Food and Drug Administration (FDA) for the treatment of nausea and vomiting associated with moderately to highly emetogenic chemotherapy and prevention of postoperative nausea and vomiting (PONV) in adults.

**Background:**

Few side effects of cancer treatment are more feared by patients than nausea and vomiting. Although nausea and emesis (vomiting and/or retching) can result from surgery or radiation therapy, chemotherapy-induced nausea and vomiting (CINV) is potentially the most severe and most distressing. Significant progress has been made, but CINV remains an important adverse effect of treatment.

Three distinct types of CINV have been defined, with important implications for both prevention and management:

- Acute emesis, which most commonly begins within one to two hours of chemotherapy and usually peaks in four to six hours
- Delayed emesis, occurring more than 24 hours after chemotherapy
- Anticipatory emesis, occurring prior to treatment as a conditioned response in patients who have developed significant nausea and vomiting during previous cycles of chemotherapy

The objective of antiemetic therapy is the complete prevention of CINV, and this should be achievable in the majority of patients receiving chemotherapy, even with highly emetic agents.

The most important factor determining the likelihood of acute or delayed emesis developing during chemotherapy is the intrinsic emetogenicity of the particular agent. Although other factors may be important, such as patient age, sex, and history of alcohol consumption, these factors are not currently used to select the antiemetic strategy.

The management of CINV has been greatly facilitated by the development of classification schemes that reflect the likelihood of emesis developing following treatment with particular agents. A 1997 classification scheme gained broad acceptance and was utilized as the basis for treatment recommendations by guideline panels. A modification of this schema was proposed at the 2004 Perugia Antiemetic Consensus Guideline meeting and is

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still relevant, although many more chemotherapy agents are now available. Chemotherapy agents were divided into four categories based upon the risk of emesis in the absence of antiemetic prophylaxis:

- Highly emetic – >90 percent risk of emesis
- Moderately emetic – >30 to 90 percent risk of emesis
- Low emetogenicity – 10 to 30 percent risk of emesis
- Minimally emetic – <10 percent risk of emesis

This drug classification schema is utilized in both the updated antiemetic guidelines of the Multinational Association of Supportive Care in Cancer (MASCC)/European Society for Medical Oncology (ESMO) and the American Society of Clinical Oncology (ASCO).

For combination regimens, the emetic level is determined by identifying the most emetic agent in the combination and then assessing the relative contribution of the other agents.

**Approved Indications**

A. Prevention of postoperative nausea and vomiting (PONV) [aprepitant oral capsule].
B. In combination with other antiemetic agents (oral 5HT3 antagonist and dexamethasone) for prevention of:
    a. Acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin.
    b. Nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC).

**Other Uses**

i. N/A

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## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| HCPCS | Description |
|---|---|
| J8501 | APREPITANT, ORAL, 5 MG |
| J8540 | DEXAMETHASONE, ORAL, 0.25 MG |
| J8650 | NABILONE, ORAL, 1 MG |
| J8655 | NETUPITANT 300 MG AND PALONOSETRON 0.5 MG, ORAL |
| J8670 | ROLAPITANT, ORAL, 1 MG |
| Q0161 | CHLORPROMAZINE HYDROCHLORIDE, 5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0162 | ONDANSETRON 1 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0163 | DIPHENHYDRAMINE HYDROCHLORIDE, 50 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT TIME OF CHEMOTHERAPY TREATMENT NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0164 | PROCHLORPERAZINE MALEATE, 5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0166 | GRANISETRON HYDROCHLORIDE, 1 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 24 HOUR DOSAGE REGIMEN |
| Q0167 | DRONABINOL, 2.5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0169 | PROMETHAZINE HYDROCHLORIDE, 12.5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI- |

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| | EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0173 | TRIMETHOBENZAMIDE HYDROCHLORIDE, 250 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0174 | THIETHYLPERAZINE MALEATE, 10 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0175 | PERPHENAZINE, 4 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0177 | HYDROXYZINE PAMOATE, 25 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN |
| Q0180 | DOLASETRON MESYLATE, 100 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 24 HOUR DOSAGE REGIMEN |

| ICD-10 | Description |
|---|---|
| C00.0-C96.9 | Malignant neoplasms |
| R11.0-R11.2 | Nausea and vomiting |
| Z51.11-Z51.12 | Encounter for antineoplastic chemotherapy |
| T45.1X5A - T45.1X5S | Adverse effect of antineoplastic and immunosuppressive drugs |
| T45.95XA | Adverse effect of unspecified primarily systemic and hematological agent, initial encounter |
| T50.905A | Adverse effect of unspecified drugs, medicaments and biological substances |

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## Medical Necessity Guidelines

When a drug is being reviewed for coverage under a member's medical benefit plan or is otherwise subject to clinical review (including prior authorization), the following criteria will be used to determine whether the drug meets any applicable medical necessity requirements for the intended/prescribed purpose.

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

### Clinical Criteria

**B vs D Criteria:** All drugs included in this PA are subject to B vs D evaluation. Medication must be furnished "incident to" physician service provided and usually not self-administered to be covered by Medicare and to be eligible to be evaluated through part B. If not, medication must be evaluated through part D.

### Aprepitant (EMEND®)

A. **Criteria for Initial Approval** (*Provider must submit documentation [such as office chart notes, lab results, pathology reports, imaging studies, and any other pertinent clinical information] supporting the patient's diagnosis for the drug and confirming that the patient has met **all** approval criteria.)*

I. Individual will use Emend with an oral $5HT_3$ antagonist, and oral dexamethasone; **AND**
II. Individual is receiving one or more of the following anti-cancer chemotherapeutic agents:
   a. Alemtuzumab; **OR**
   b. Azacitidine; **OR**
   c. Bendamustine; **OR**
   d. Carboplatin; **OR**
   e. Carmustine; **OR**
   f. Cisplatin; **OR**
   g. Clofarabine; **OR**
   h. Cyclophosphamide; **OR**
   i. Cytarabine; **OR**
   j. Dacarbazine; **OR**
   k. Daunorubicin; **OR**
   l. Doxorubicin; **OR**
   m. Epirubicin: **OR**
   n. Idarubicin; **OR**
   o. Ifosfamide; **OR**
   p. Irinotecan; **OR**
   q. Lomustine; **OR**
   r. Mechlorethamine; **OR**

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s. Oxaliplatin; **OR**
t. Streptozocin;

**AND**

III. Individual will start the oral three drug regimen (including aprepitant) immediately before and within 48 hours after the administration of these chemotherapeutic agents.

**B. Criteria for Continuation of Therapy**

I. MMM considers continuation aprepitant therapy medically necessary in members requesting reauthorization for an indication listed in Section A above (Criteria for Initial Approval) when all the above criteria are met.

C. **Authorization Duration**

I. Initial Authorization Duration: 1 year
II. Reauthorization: 1 year

**D. Conditions not covered**

I. Aprepitant is not covered under Medicare Part B when used in combination regimens that include both oral and intravenous (IV) antiemetic drugs for patients receiving highly or moderately emetogenic chemotherapy; **OR**
II. Requested for a diagnosis not related to cancer; **OR**
III. When used as part of an antiemetic drug regimen that includes both oral and intravenous (IV) forms of administration; **OR**
IV. When used alone for anticancer chemotherapy related nausea and vomiting; **OR**
V. When used concurrently with pimozide.

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## Limits or Restrictions

A. Therapeutic Alternatives

*The list below includes preferred alternative therapies recommended in the approval criteria and may be subject to prior authorization.*

i. N/A

B. Quantity Limitations

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The chart below includes dosing recommendations as per the FDA-approved prescribing information.*

| Drug | Recommended Dosing Schedule |
|---|---|
| **Emend (aprepitant)** | 125mg on day 1 and 80mg on days 2-3 per applicable chemotherapy course. |
| **Exceptions** | |
| A single course of oral antiemetic drugs should be dispensed at a time, unless it is confirmed that more than one course of chemotherapy will occur within the same month. In either case, no more than a one-month supply of oral antiemetic drugs will be authorized. | |

## Reference Information


1. Oral antiemetic drugs (replacement for intravenous antiemetics-L33827) CMS.gov Centers for Medicare & Medicaid Services. October 1, 2015. Accessed August 23, 2023. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33827&ver=45&keyword=antiemetics&keywordType=starts&areaId=all&docType=NCA%2CCAL%2CNCD%2CMEDCAC%2CTA%2CMCD%2C6%2C3%2C5%2C1%2CF%2CP&contractOption=all&sortBy=relevance&bc=1.

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## Policy History

| Revision Type | Summary of Changes | P&T Approval Date | UM/CMPC Approval Date |
|---|---|---|---|
| Annual Review 5/9/2024 | Update clinical criteria (initial and continuation criteria), quantity limit, conditions not covered, wording and formatting updates. | 3/20/2025 | 4/2/2025 |
| Policy Inception 9/27/2023 | Elevance Health's Medical Policy adoption. | N/A | 11/30/2023 |