

<b>Clinical Policy Title:</b>	netupitant/palonosetron, fosnetupitant/palonosetron
<b>Policy Number:</b>	RxA.334
<b>Drug(s) Applied:</b>	Akynzeo®
<b>Original Policy Date:</b>	03/06/2020
<b>Last Review Date:</b>	10/19/2023
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Prevention of Nausea and Vomiting Associated with Cancer Chemotherapy (must meet all):

1. Prescribed for the prevention of chemotherapy-induced nausea/vomiting;
2. Age ≥ 18 years;
3. Trial and failure of a 5-HT3 receptor antagonist (ondansetron is preferred), unless contraindicated or clinically significant adverse effects are experienced;
4. Trial and failure of an NK1 antagonist (aprepitant is preferred), unless contraindicated or clinically significant adverse effects are experienced;  
Prior authorization is required for aprepitant.
5. Prescribed in combination with dexamethasone;
6. If request is for Akynzeo® capsules, dose does not exceed netupitant 300 mg/palonosetron 0.5 mg (1 capsule) per chemotherapy cycle;
7. If request is for Akynzeo® for injection, dose does not exceed fosnetupitant 235 mg/palonosetron 0.25 mg (1 vial) per chemotherapy cycle.

#### Approval Duration

**Commercial:** Projected course of chemotherapy

**Medicaid:** Projected course of chemotherapy

### II. Continued Therapy Approval

#### A. Prevention of Nausea and Vomiting Associated with Cancer Chemotherapy (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy;
3. Prescribed in combination with dexamethasone;
4. If request is for a dose increase of Akynzeo® capsules, new dose does not exceed netupitant 300 mg/palonosetron 0.5 mg (1 capsule) per chemotherapy cycle;
5. If request is for a dose increase of Akynzeo® for injection, new dose does not exceed fosnetupitant 235 mg/palonosetron 0.25 mg (1 vial) per chemotherapy cycle.

#### Approval Duration

**Commercial:** Projected course of chemotherapy

**Medicaid:** Projected course of chemotherapy

## References

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

1. National Comprehensive Cancer Network. Antiemesis Version 2.2022. Available at [https://www.nccn.org/professionals/physician\\_gls/pdf/antiemesis.pdf](https://www.nccn.org/professionals/physician_gls/pdf/antiemesis.pdf) . Accessed September 12, 2022.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	08/16/2021	12/7/2021
Policy was reviewed: 1. References were reviewed and updated.	09/12/2022	10/19/2022
Policy was reviewed.	10/19/2023	10/19/2023