Evolent Clinical Guideline 3264 for Antiemetics

Guideline Number:	Applicable Codes	
Evolent_CG_3264		
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STATEMENT

Purpose

To define and describe the accepted indications for Antiemetics usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

INDICATIONS

Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided

- The member has not experienced disease progression on the requested medication AND
- The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization AND
- Additional medication(s) are not being added to the continuation request.

Antiemesis

- Zofran (ondansetron), Kytril (granisetron), Aloxi (palonosetron), Sustol (granisetron extended release), Akynzeo (netupitant oral/fosnetupitant injection + palonosetron), Sancuso (granisetron patch) may be used as prophylaxis prior to the administration of low, moderate, or high emetogenic risk chemotherapy.
    - Only Zofran (ondansetron) or Kytril (granisetron) can be used [see exclusion criteria for other antiemetics]:
        - Before radiation to the upper abdomen or total body irradiation OR
        - Treatment for nausea/vomiting induced by radiation or anticancer therapy.
- Emend (fosaprepitant injection or aprepitant oral), Focinvez (fosaprepitant injection), Cinvanti (aprepitant injection), or Varubi (rolapitant oral) should be used in combination with dexamethasone and one of the following serotonin (5-HT3) antagonists: Zofran (ondansetron) or Kytril (granisetron) or Aloxi (palonosetron) prior to the administration of low, moderate, or high emetogenic risk chemotherapy.

CONTRAINDICATIONS/WARNINGS

- Contraindications
  - Ondansetron
    - Hypersensitivity to ondansetron or any component of the formulation
    - Concomitant use with apomorphine
  - Palonosetron
    - Known hypersensitivity to palonosetron or any component of the formulation
  - Granisetron, granisetron extended release, granisetron patch
    - Hypersensitivity to granisetron or any component of the formulation or to other 5-HT3 receptor antagonists
  - Fosaprepitant injection/oral aprepitant
    - Hypersensitivity to fosaprepitant or aprepitant, or any component of the formulations
    - Concurrent use with pimozide
    - Significant drug interactions exist, requiring dose/frequency adjustment or avoidance. Consult drug interactions database for more information
  - Rolapitant
    - Concurrent use of CYP2D6 substrates with a narrow therapeutic index, such as thioridazine or pimozide; pediatric patients <2 years of age
    - Significant drug interactions exist, requiring dose/frequency adjustment or avoidance. Consult drug interactions database for more information

EXCLUSION CRITERIA

- Aloxi (palonosetron), Akynzeo (netupitant oral /fosnetupitant injection-palonosetron), Sancuso (granisetron patch), Sustol (granisetron extended release), Emend (fosaprepitant injection/oral aprepitant), Focinvez (fosaprepitant injection), Cinvanti (aprepitant injection), or Varubi (rolapitant oral) is being used for the prevention or treatment of radiation or total body irradiation induced nausea and vomiting or for the treatment of breakthrough nausea/vomiting.
- Emend (fosaprepitant injection/oral aprepitant), Focinvez (fosaprepitant injection), Cinvanti (aprepitant injection), or Varubi (rolapitant oral) is being used without a 5HT3 receptor antagonist [e.g., Zofran (ondansetron)/Kytril (granisetron)/Aloxi (palonosetron0] and dexamethasone.
- Dose exceeds the maximum single dose limits for Zofran 16 mg (IV), Zofran 24 mg (PO), Granisetron 2 mg (IV/PO), Sancuso 3.1 mg patch, Aloxi 0.25 mg (IV), Aloxi 0.5 mg (PO), Akynzeo 300 mg/0.5 mg (PO) or 235 mg/0.25 mg (IV), and Sustol 10 mg.

- Dosing exceeds the single dose limit of aprepitant oral 125 mg, fosaprepitant injection 150 mg, rolapitant oral 180 mg, or aprepitant injection 130 mg.
- Investigational use of Antiemetics with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
    - Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
    - Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
    - Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definition of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
    - Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
    - That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
    - That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
    - That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

CODING AND STANDARDS

Codes

- J2405 - Injection, ondansetron hydrochloride, per 1 mg
- 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
- S0119 - Ondansetron, oral, 4 mg (for circumstances falling under the medicare statute, use hcpcs q code)
- J1626 - Injection, granisetron hydrochloride, 100 mcg
- J1627 - Injection, granisetron, extended-release, 0.1 mg

- J3490 - granisetron transdermal patch (3.1 mg/24 hours)
- 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
- S0091 - Granisetron hydrochloride, 1 mg (for circumstances falling under the medicare statute, use q0166)
- J2468 - Injection, palonosetron hydrochloride (posfrea), 25 micrograms
- J2469 - Injection, palonosetron hcl, 25 mcg
- J1454 - Injection, fosnetupitant 235 mg and palonosetron 0.25 mg
- J8655 - Netupitant 300 mg and palonosetron 0.5 mg, oral
- C9145 - Injection, aprepitant, (aponvie), 1 mg
- J0185 - Injection, aprepitant, 1 mg
- J1434 - Injection, fosaprepitant (focinvez), 1 mg
- J1453 - Injection, fosaprepitant, 1 mg
- J1456 - Injection, fosaprepitant (teva), not therapeutically equivalent to j1453, 1 mg
- J8501 - Aprepitant, oral, 5 mg
- J2797 - Injection, rolapitant, 0.5 mg
- J8670 - Rolapitant, oral, 1 mg

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
May 2026	• Added “Focinvez (fosaprepitant injection)” to all relevant sections • Updated references
January 2026	• Converted to new Evolent guideline template • This guideline replaces UM ONC_1468 Antiemetics • Updated exclusion criteria • Updated references
January 2025	• Added Evolent disclaimer language • Added Coding Information section with HCPCS code

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members’ health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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