This information was supplied by the NC Medicaid Division of Health Benefits.

NC Division of Medical Assistance **Outpatient Pharmacy** **Prior Approval Criteria** **Antiemetic Agents**	**Medicaid and Health** **Effective Date: 09/15/2010** **Revised Date: 06/12/2017**

Therapeutic Class Code: H6J
Therapeutic Class Description: Antiemetic Agents

Medication	Generic Code Number(s)	NDC Number(s)
Emend/ aprepitant	19365, 19366, 19367, 27278, 40344	

Eligible Beneficiaries
NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries**.

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21

Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.
EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at http://www.ncdhhs.gov/dma/epsdt/.

Criteria:

- Beneficiary undergoing surgery and requires prevention of postoperative nausea and vomiting.

OR

- Beneficiary receiving highly emetogenic or moderately emetogenic chemotherapy agent

AND

- Concurrent use of dexamethasone (needed for regimen)
- Beneficiary must also have tried and failed or is intolerant to generic ondansetron, Zofran, Kytril or Anzemet.
- **Dosage limits apply to each cycle:**
  - 125mg daily for one day
  - Up to 80mg daily for 2 days.

Procedure:

Length of therapy may be approved for up to 12 months.

References

1. Antiemetic Agents, Topical. Drug Facts and Comparisons, Drug Facts and Comparisons, Wolters Kluwer Health. St. Louis (MO): updated monthly.
2. Prescriber Information-Emend ® (aprepitant), Merck and Co., Inc., Whitehouse Station, NJ., March 2010.

Criteria Change Log

09/15/2010	Criteria effective date
06/15/2012	Combined with NC Health Choice
06/12/2017	Added generic aprepitant to criteria and GCN 40344