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 Policy Number: C20780-A

Antiemetics

PRODUCTS AFFECTED

Akynzeo (fosnetupitant/palonosetron; netupitant/palonosetron), Aloxi (palonosetron), Anzemet (dolasetron), Aponvie (aprepitant), aprepitant, Cinvanti (aprepitant), Emend (aprepitant/fosaprepitant), Focinvez (fosaprepitant inj), fosaprepitant, palonosetron, Posfrea (palonosetron), Sancuso (granisetron) patch, Sustol (granisetron) PFS, Varubi (rolapitant)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:

Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:

Chemotherapy-induced nausea/vomiting (CINV) prophylaxis, Post-operative nausea/vomiting (PONV) prophylaxis

REQUIRED MEDICAL INFORMATION:

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

Drug and Biologic Coverage Criteria

A. CHEMOTHERAPY INDUCED NAUSEA/VOMITING PROPHYLAXIS:

1. Documentation of the treatment plan including the names all of chemotherapy and or radiation agents, frequency, length, cycle and duration of therapy
AND
2. Product being requested has an FDA labeled indication or compendia supported use for diagnosis, age, and dose
AND
3. Prescriber attests that medication will be used in combination (when indicated per FDA label or guideline) with other antiemetic agents (5HT3 antagonist) OR used in combination with corticosteroid such as dexamethasone, unless documentation of contraindication to dexamethasone is provided, per FDA label or NCCN guideline
AND
4. Prescriber attests that medication will NOT be used with additional agents if FDA label or guideline does not support concurrent therapy
AND
5. Prescriber attests to review of concurrent medication therapy for drug-drug interactions OR clinical reviewer has not found any unmanaged drug-drug interactions
AND
6. FOR PALONOSETRON (ALOXI), ANZEMET ONLY: FOR HIGH EMETIC IV CHEMOTHERAPY AND CONCURRENTLY RECEIVING APREPITANT OR FOSAPREPITANT ONLY: Documentation of trial and failure of or labeled contraindication to preferred serotonin-receptor antagonists [ondansetron and granisetron (any dosage form)]
AND
7. FOR SANCUSO AND SUSTOL: Documentation of trial and failure or labeled contraindication of preferred serotonin-receptor antagonist [ondansetron and granisetron (any dosage form)]
AND
8. FOR VARUBI ONLY: (a)Documentation that the member has experienced inadequate response or contraindication to aprepitant/fosaprepitant AND generic oral ondansetron or generic oral granisetron WITH dexamethasone AND (b) Prescriber attests that Varubi (rolapitant) will not be administered any less than a 2-week interval between doses
NOTE: The proper succession for these criteria can be found within compendia monographs, FDA label or NCCN guidelines; If compendia monographs, FDA label or NCCN guidelines have a formulary/preferred product at therapeutic parity with requested agent a formulary/preferred product should be used first where state regulations allow. Molina reviewers and delegates will comply with all regulations and requirements applicable to the review of the request, providing exception to our standard criteria as may be required under state regulations and requirements.

B. POST-OPERATIVE NAUSEA/VOMITING PROPHYLAXIS:

1. Documentation of expected surgery date (within the next 30 days)
AND
2. Product being requested has an FDA labeled indication or compendia supported use for diagnosis, age and dose
AND
3. Prescriber attests to a historical trial and failure or labeled contraindication to preferred serotonin-receptor antagonists (ondansetron and IV granisetron)

CONTINUATION OF THERAPY:

A. CHEMOTHERAPY INDUCED NAUSEA/VOMITING PROPHYLAXIS:

1. Documentation of continuation of chemotherapy requiring antiemetics.
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity or development of contraindications (e.g., hypersensitivity reactions, serotonin syndrome, etc.)

Drug and Biologic Coverage Criteria

B. POST-OPERATIVE NAUSEA/VOMITING PROPHYLAXIS: N/A Each procedure request should be a new review

DURATION OF APPROVAL:

Post-Operative nausea/vomiting prophylaxis: Initial authorization: 1 month, Continuation of Therapy: N/A

Chemotherapy Induced Nausea/Vomiting Prophylaxis: Initial authorization: 6 months (or length of chemotherapy or radiation therapy, whichever is shorter), Continuation of Therapy: 6 months (or length of chemotherapy or radiation, whichever is shorter)

PRESCRIBER REQUIREMENTS:

No requirements

AGE RESTRICTIONS:

Akynzeo (fosnetupitant/palonosetron; netupitant/palonosetron): 18 years of age or older

Aloxi (palonosetron): Highly and moderately emetogenic cancer chemotherapy (HEC, MEC): 1 month of age and older; Postoperative nausea and vomiting (PONV) for up to 24 hours following surgery: 18 years and older

Anzemet (dolasetron): 2 years of age and older

Aponvie (aprepitant): 18 years of age and older

Cinvanti: 18 years of age or older

Emend oral suspension or injection, Focinvez injection: 6 months of age or older

Emend capsules: 12 years of age or older

Posfrea (palonosetron): 18 years of age and older Sancuso: 18 years of age and older

Sustol (granisetron ER inj): 18 years of age and older

Varubi (rolapitant): 18 years of age and older

QUANTITY:

Akynzeo (fosnetupitant/palonosetron; netupitant/palonosetron): Maximum 1 day per cycle of chemotherapy

Aloxi (palonosetron): FOR CINV PROPHYLAXIS: Adults: (0.25mg/5ml) 1 vial per 7-day supply or 1

capsule one hour prior to the start of chemotherapy, Pediatrics <17 years of age: 20 mcg/kg IV single

dose up to a maximum dose of 1500mcg; FOR PONV: 0.075mg approved ONCE per authorization

Anzemet (dolasetron): Adults – 100mg given within 1 hour before chemotherapy; Pediatric patients 2-16:

1.8 mg/kg given within 1 hour before chemotherapy up to a maximum of 100mg Aponvie (aprepitant): 32mg

IV injection ONCE per authorization

Cinvanti (aprepitant): 130 mg on Day 1 for HEC and MEC (single-dose regimen), or 100 mg on Day 1 for MEC (3-day regimen).

Emend (aprepitant capsules, oral suspension), Emend (fosaprepitant inj): CINV: oral suspension

or capsules: Dose does not exceed 125 mg on Day 1, followed by 80mg on Days 2 and 3 per chemotherapy cycle; injection: 150 mg on Day 1; [Pediatric doses are weight based and should follow FDA label for members 6 months to 12 years of age]

Emend (aprepitant capsules): PONV: Dose does not exceed 40 mg (1 capsule) once Focinvez (fosaprepitant inj): 150 mg on Day 1; [Pediatric doses are age and weight based and should follow FDA label for members 6 months to 17 years of age]

Posfrea (palonosetron inj): CINV: 0.25 mg IV once; PONV: 0.075mg approved ONCE per authorization

Sancuso (granisetron patches), Sustol (granisetron ER inj.), and granisetron injection: quantity not to exceed FDA label per indication

Varubi (rolapitant): 180 mg on day 1 of chemo every 14 days

Quantities above the plan limit for chemotherapy induced nausea/vomiting will be approved when ONE of the following is met:

1. The member has cancer chemotherapy related nausea and vomiting and will be receiving chemotherapy more than 7 days per month

OR

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Drug and Biologic Coverage Criteria

2. *The member has delayed emesis in highly emetogenic chemotherapy OR*
3. *The member has radiation therapy induced nausea and vomiting and radiation treatment that extends beyond 7 days per month*
OR
4. *The prescriber has submitted documentation in support of the requested therapeutic use and quantity for the requested medication which has been reviewed and approved by the Clinical Review pharmacist*

PLACE OF ADMINISTRATION:

The recommendation is that oral and transdermal medications in this policy will be for pharmacy benefit coverage and patient self-administered.

The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-inpatient hospital facility-based location.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Oral, Intravenous, Transdermal

DRUG CLASS:

Antiemetics

FDA-APPROVED USES:

AKYNZEO (netupitant and palonosetron) **capsules** is indicated:

In combination with dexamethasone in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of cancer chemotherapy, including, but not limited to, highly emetogenic chemotherapy.

AKYNZEO (fosnetupitant and palonosetron) **for injection** is indicated:

In combination with dexamethasone in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy. *Limitations of Use: AKYNZEO for injection and AKYNZEO injection have not been studied for the prevention of nausea and vomiting associated with anthracycline plus cyclophosphamide chemotherapy.*

ALOXI (palonosetron) is indicated in:

Adults for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately and highly emetogenic cancer chemotherapy (MEC) or (HEC), postoperative nausea and vomiting (PONV) for up to 24 hours following surgery. *Efficacy beyond 24 hours has not been demonstrated* Pediatric patients aged 1 month to less than 17 years for prevention of: acute nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy, including highly emetogenic cancer chemotherapy (HEC)

ANZEMET (dolasetron) is indicated for:

The prevention of nausea and vomiting associated with moderately emetogenic cancer chemotherapy, including initial and repeat courses in adults and children 2 years and older

APONVIE (aprepitant) is indicated for:

The prevention of postoperative nausea and vomiting (PONV) in adults.

Limitations of use: Aponvie has not been studied for treatment of established nausea and vomiting.

CINVANTI (aprepitant) is indicated:

In adults, in combination with other antiemetic agents, for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin as a single-dose regimen, and delayed nausea and vomiting associated with

Drug and Biologic Coverage Criteria

initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC) as a single-dose regimen, and nausea and vomiting associated with initial and repeat courses of MEC as a 3-day regimen.

Limitations of Use: CINVANTI has not been studied for treatment of established nausea and vomiting.

EMEND (aprepitant) for **oral suspension** is indicated:

In combination with other antiemetic agents, in patients **6 months of age and older** for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin or moderately emetogenic cancer chemotherapy (MEC)

EMEND (aprepitant) **capsules** is indicated:

In combination with other antiemetic agents, in patients **12 years of age and older** for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin or moderately emetogenic cancer chemotherapy (MEC)

Limitations of Use: EMEND has not been studied for treatment of established nausea and vomiting.

Chronic continuous administration of EMEND is not recommended.

EMEND, FOCINVEZ (fosaprepitant) for **injection** is indicated:

In adults and pediatric patients 6 months of age and older, in combination with other antiemetic agents, for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin or moderately emetogenic cancer chemotherapy (MEC)

Limitations of use: Emend and Focinvez have not been studied for treatment of established nausea and vomiting.

POSFREA (palonosetron) is indicated in adults for:

Prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC), prevention of acute nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC), and prevention of postoperative nausea and vomiting (PONV) for up to 24 hours following surgery.

Efficacy beyond 24 hours has not been demonstrated.

SANCUSO (granisetron transdermal) is indicated:

For prevention of nausea and vomiting in adults receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days.

SUSTOL (granisetron) ER inj. is indicated:

In combination with other antiemetics in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy (MEC) or anthracycline and cyclophosphamide (AC) combination chemotherapy regimens.

VARUBI (rolapitant) is indicated:

In combination with other antiemetic agents in adults for the prevention of delayed nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy, including, but not limited to, highly emetogenic chemotherapy

COMPENDIAL APPROVED OFF-LABELED USES:

None

APPENDIX

APPENDIX:

Antiemetics: ASCO Guideline Update J Clin Oncol 38:2782-2797. © 2020 by American Society of Clinical Oncology

Emetic Risk of Single Intravenous Antineoplastic Agents in Adults

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Drug and Biologic Coverage Criteria

Risk Level High (>90%)

Anthracycline/cyclophosphamide combination
Carmustine
Cyclophosphamide > 1,500 mg/m²

Dacarbazine
Mechlorethamine
Streptozocin

Moderate (30%-90%)

Alemtuzumab
Arsenic trioxide
Azacitidine
Bendamustine
Busulfan
Carboplatin
Clofarabine
Cyclophosphamide, 1,500mg/m²
Cytarabine 1,000 mg/m²
Daunorubicin
Daunorubicin and cytarabine liposome

Doxorubicin
Epirubicin
Fam-trastuzumabderuxtecan-nxki
Idarubicin
Ifosfamide
Irinotecan
Irinotecan liposomal injection
Oxaliplatin
Romidepsin
Temozolomide
Thiotepab
Trabected

Low (10%-30%)

Aflibercept
Axicabtagene ciloleucel
Belinostat
Blinatumomab
Bortezomib
Brentuximab
Cabazitaxel
Carfilzomib
Catumaxumab
Cetuximab
Copanlisib
Cytarabine # 1,000 mg/m²
Decitabine
Docetaxel
Elotuzumab
Enfortumab vedotin-ejfv
Eribulin
Etoposide
Fluorouracil
Gemcitabine
Gemtuzumab ozogamicin
Inotuzumab ozogamicin

Ixabepilone
Methotrexate
Mitomycin
Mitoxantrone
Moxetumomab
pasudotox
Nab-paclitaxel
Necitumumab
Nelarabine
Paclitaxel
Panitumumab
Pegylated
liposomal
doxorubicin
Pemetrexed
Pertuzumab
Tagraxofusp-erzs
Temsilolimus
Tisagenlecleucel
Topotecan
Trastuzumab-emtansine
Vinflunine

Minimal (<10%)

Atezolizumab
Avelumab
Bevacizumab
Bleomycin
Cemiplimab
Chlorodeoxyadenosine
Cladribine
Daratumumab
Durvalumab
Emapalumab
Fludarabine
Ipilimumab

Nivolumab
Obinutuzumab
Ofatumumab
Pembrolizumab
Pixantrone
Polatuzumab vedotin
Pralatrexate
Ramucirumab
Rituximab
Trastuzumab
Vinblastine
Vincristine
Vinorelbine

Drug and Biologic Coverage Criteria

Emetic Risk of Single, Oral Antineoplastic Agents in Adults

Moderate or high ($\geq 30\%$)

Abemaciclib	Lenvatinib
Avapritinib	Lomustine
Bosutinib	Midostaurin
Cabozantinib	Niraparib
Ceritinib	Procarbazine
Crizotinib	Ribociclib
Cyclophosphamide	Rucaparib
Enasidenib	Selinexor
Fedratinib	TAS-102 (trifluridine-tipiracil)
Hexamethylmelamine	Temozolomide
Imatinib	Vinorelbine

Minimal or low ($< 30\%$)

6-Thioguanine	Lapatinib
Acalabrutinib	Larotrectinib
Afatinib	Lenalidomide
Alectinib	Lorlatinib
Alpelisib	Melphalan
Axitinib	Methotrexate
Bexarotene	Neratinib
Brigatinib	Nilotinib
Capecitabine	Olaparib
Chlorambucil	Osimertinib
Cobimetinib	Palbociclib
Dabrafenib	Panobinostat
Dacomitinib	Pazopanib
Dasatinib	Pexidartinib
Duvelisib	Pomalidomide
Encorafenib	Ponatinib
Entrectinib	Regorafenib
Erdafitinib	Ruxolitinib
Erlotinib	Sonidegib
Estramustine	Sorafenib
Etoposide	Sunitinib
Everolimus	Talazoparib
Fludarabine	Tazemetostat
Gefitinib	Tegafur-Uracil
Gilteritinib	Thalidomide
Glasdegib	Topotecan
Hydroxyurea	Trametinib
Ibrutinib	Vandetanib
Idelalisib	Vemurafenib
Ivosidenib	Venetoclax
Ixazomib	Vismodegib
	Vorinostat
	Zanubrutinib

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

None

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of antiemetics are considered experimental/investigational and therefore, will follow

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Molina's Off-Label policy.

Contraindications to Akynzeo (fosnetupitant-palonosetron; netupitant-palonosetron) include: No labeled contraindications

Contraindications to Aloxi (palonosetron), Posfrea (palonosetron) include: Hypersensitivity to palonosetron

Contraindications to Anzemet (dolasetron) include: Patients known to have hypersensitivity to the drug

Contraindications to Aponvie (aprepitant) include: Known hypersensitivity to any component of the product, concurrent use with pimozone, avoid concomitant use with strong CYP3A4 inhibitors (ketoconazole, itraconazole, nefazodone, troleandomycin, clarithromycin, ritonavir, nelfinavir) and strong CYP3A4 inducers (rifampin, carbamazepine, phenytoin), avoid use in pregnant women (due to the alcohol content).

Contraindications to Cinvanti (aprepitant) include: Known hypersensitivity to any component of the drug, concurrent use with pimozone, avoid concomitant use with moderate to strong CYP3A4 inhibitors (diltiazem, ketoconazole, itraconazole, nefazodone, troleandomycin, clarithromycin, ritonavir, nelfinavir) and strong CYP3A4 inducers (rifampin, carbamazepine, phenytoin)

Contraindications to Emend (aprepitant, fosaprepitant), Focinvez (fosaprepitant) include: Known hypersensitivity to any component of the drug, concurrent use with pimozone, avoid concomitant use with moderate to strong CYP3A4 inhibitors (diltiazem, ketoconazole, itraconazole, nefazodone, troleandomycin, clarithromycin, ritonavir, nelfinavir) and strong CYP3A4 inducers (rifampin, carbamazepine, phenytoin)

Contraindications to Granisetron include: Patients with known hypersensitivity to the drug or any of its components

Contraindications to Sancuso (granisetron) include: Known hypersensitivity to granisetron or to any of the components of the transdermal system

Contraindications to Sustol (granisetron) include: Hypersensitivity to granisetron, any of the components of Sustol, or to any of the other 5-HT₃ receptor antagonists

Contraindications to Varubi (rolapitant) include: Patients taking CYP2D6 substrates with a narrow therapeutic index (e.g., thioridazine and pimozone), and pediatric patients less than 2 years of age because of irreversible impairment of sexual development and fertility in juvenile rats, avoid in patients who require chronic administration of strong CYP3A4 inducers (e.g., rifampin)

OTHER SPECIAL CONSIDERATIONS:

Serotonin syndrome has been reported with 5-HT₃ receptor antagonists alone but particularly with concomitant use of serotonergic drugs.

Emend for oral suspension should be prepared by healthcare provider. Once prepared, it may be administered either by a healthcare provider, patient, or caregiver.

Sustol is intended for subcutaneous injection by a health care provider.

CODING/BILLING INFORMATION

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.

Drug and Biologic Coverage Criteria

HCPCS CODE	DESCRIPTION
J0185	Injection, aprepitant, 1 mg
J1434	Injection, fosaprepitant (focinvez), 1 mg
J1453	Injection, fosaprepitant, 1 mg
J1454	Injection, fosnetupitant 235mg/ palonosetron 0.25mg
J1456	Injection, fosaprepitant (teva), not therapeutically equivalent to J1453, 1 mg
J1627	Injection, granisetron, extended-release, 0.1 mg
J2468	Injection, palonosetron hydrochloride (posfrea), 25 micrograms
J3490	Unclassified drug (Aponvie)

AVAILABLE DOSAGE FORMS:

Akynzeo (Ready-to-Use) SOLN 235-0.25MG/20ML
 Akynzeo (To-be-Diluted) SOLN 235-0.25MG/20ML
 Akynzeo CAPS 300-0.5MG
 Akynzeo SOLR 235-0.25MG
 Anzemet TABS 50MG
 Aponvie EMUL 32MG/4.4ML
 Aprepitant CAPS 40MG, 80MG, 125MG
 Aprepitant CAPS 80 & 125MG
 Cinvanti EMUL 130MG/18ML
 Emend BiPack CAPS 80MG
 Emend SOLR 150MG
 Emend SUSR 125MG/5ML
 Emend Tri-Pack CAPS 80 & 125MG
 Focinvez SOLN 150MG/50ML
 Fosaprepitant Dimeglumine SOLR 150MG
 Posfrea SOLN 0.25MG/5ML
 Sancuso PTCH 3.1MG/24HR
 Sustol PRSY 10MG/0.4ML
 Varubi (180 MG Dose) TBPK 2 x 90MG

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2. Aloxi (palonosetron) capsules [prescribing information]. Iselin, NJ: Helsinn Therapeutics (US) Inc; April 2020.
3. Aloxi (palonosetron) injection [prescribing information]. Iselin, NJ: Helsinn Therapeutics (US) Inc; April 2020.
4. Anzemet (dolasetron) tablets [prescribing information]. Parsippany, NH: Validus Pharmaceuticals LLC; June 2021.
5. Aponvie (aprepitant) injectable emulsion for intravenous use [prescribing information]. San Diego, CA: Heron Therapeutics, Inc.; September 2022.
6. Aprepitant [prescribing information]. Princeton, NJ: Sandoz Inc; December 2020.
7. Cinvanti (aprepitant) injectable emulsion, for intravenous use [prescribing information]. San Diego, CA: Heron Therapeutics; March 2024.
8. Emend (aprepitant) capsules, oral suspension [prescribing information]. Rahway, NJ: Merck Sharp & Dohme LLC; May 2022.
9. Emend (fosaprepitant) for injection [prescribing information]. Rahway, NJ: Merck Sharp & Dohme LLC; May 2022.
10. Focinvez (fosaprepitant injection) for intravenous use [prescribing information]. Bridgewater, NJ: Amneal Pharmaceuticals LLC; July 2023.

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11. Posfrea (palonosetron) injection, for intravenous use [prescribing information]. New Jersey 07054, USA: Avyxa Pharma, LLC; July 2024.
12. Sancuso (granisetron transdermal) [prescribing information]. Bedminster, NJ: Kyowa Kirin; July 2024.
13. Sustol (granisetron) extended-release injection, for subcutaneous use [prescribing information]. San Diego, CA: Heron Therapeutics; May 2023.
14. Varubi (rolapitant) tablets [prescribing information]. Deerfield, IL: TerSera Therapeutics LLC; August 2020.
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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Coding/Billing Information Available Dosage Forms References	Q1 2026
REVISION- Notable revisions: Products Affected Required Medical Information Continuation of Therapy Age Restrictions Quantity FDA-Approved Uses Contraindications/Exclusions/ Discontinuation Coding/Billing Information Available Dosage Forms References	Q1 2025

Drug and Biologic Coverage Criteria

<p>REVISION- Notable revisions: Required Medical Information Continuation of Therapy FDA-Approved Uses Compendial Approved Off-Labeled Uses Other Special Considerations Available Dosage Forms References</p>	<p>Q1 2024</p>
<p>REVISION- Notable revisions: Products Affected Age Restrictions Quantity FDA-Approved Uses Contraindications/Exclusions/Discontinuation Coding/Billing Information Available Dosage Forms References</p>	<p>Q3 2023</p>
<p>REVISION- Notable revisions: Products Affected Diagnosis Required Medical Information Continuation of Therapy Age Restrictions Quantity FDA-Approved Uses Contraindications/Exclusions/Discontinuation Other Special Considerations Coding/Billing Information Available Dosage Forms References</p>	<p>Q1 2023</p>
<p>Q2 2022 Established tracking in new format</p>	<p>Historical changes on file</p>