Field Name	Field Description
Prior Authorization Group Description	**5-Hydroxytryptamine-3 Serotonin Receptor Antagonists (5-HT3 RA), Substance P/Neurokinin 1 Receptor Antagonists (NK1 RA), and Combination Agents**
Drugs	Preferred (Step 1): 5-HT3 RA: ondansetron (Zofran) IV solution, injection (IV/SQ) solution or granisetron (Kytril) IV solution NK1 RA: fosapreptiant (Emend) IV emulsion Preferred (Step 2): 5-HT3 RA palonosetron (Aloxi) 0.25 mg/2 mL IV solution Non-Preferred: Sustol (granisetron ER) SQ injection, palonosetron (Aloxi) 0.25 mg/5 mL IV solution, Cinvanti (aprepitant) IV emulsion, Varubi (rolapitant) IV emulsion, Akynzeo (palonosetron/netupitant), IV solution, Focinvez (fosaprepitant) Any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	None
Prescriber Restrictions	Prescribed by a specialist in the field to treat the patient's respective medical condition
Coverage Duration	If all of the conditions are met, the request will be approved for up to 6 months or as long as recommended by the medical compendium and/or per the NCCN/ASCO standard of care guidelines.
Other Criteria	• The medication is being requested for a Food and Drug Administration (FDA) approved indication or a medical condition that is supported by the medical compendium, the National Comprehensive Cancer Network (NCCN), and/or American Society of Clinical Oncology (ASCO) standard of care guidelines for antiemetic therapy. • The requested dosing of the 5-HT3 RA and/or NK1 RA is within FDA approved, NCCN/ASCO or other medical compendia standard of care guidelines • Patients meeting one of the following criteria may receive the generic 5-HT3 RA palonosetron hydrochloride 0.25 mg/2 mL without prior trial and failure of ondansetron/granisetron o Adult patients receiving an antineoplastic agent with

	HIGH or MODERATE emetic risk per the NCCN Practice Guidelines o Pediatric patients receiving an antineoplastic agent with HIGH emetic risk per the NCCN Practice Guidelines who are unable to receive dexamethasone • For all other patients, if the medication request is for any 5-HT3 RA other than ondansetron, granisetron or an NK1-RA other than fosaprepitant IV emulsion: o The patient has a documented treatment failure after receiving an adequate trial of a preferred 5-HT3 RA and a preferred NK1 RA and/or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc.) for not utilizing these medications to treat their medical condition. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**
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