NC Medicaid
Outpatient Pharmacy
Prior Approval Criteria
Antiemetic Agents

Medicaid and Health Choice

Effective Date: 09/15/2010
Revised Date: 03/17/2021

Therapeutic Class Code: H6J
Therapeutic Class Description: Antiemetic Agents

Medication
Emend/ aprepitant

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

a. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide,* sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***NCTracks Provider Claims and Billing Assistance Guide*:**
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page:
https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaid-benefit-children-and-adolescents

Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Beneficiaries ages 6 through 18 years of age

EPSDT does not apply to NCHC beneficiaries. If a NCHC beneficiary does not meet the clinical coverage criteria within **the Outpatient Pharmacy prior approval** clinical coverage criteria, the NCHC beneficiary shall be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes shall be covered for NCHC beneficiaries.

Criteria:

- Beneficiary is receiving:
  - Highly emetogenic chemotherapy OR
  - Carboplatin-based chemotherapy regimen OR
  - High-dose chemotherapy and stem cell or bone marrow transplantation
  - 4 or 5 day cisplatin-based chemotherapy regimen

AND

- Beneficiary is receiving concurrent use of dexamethasone (needed for regimen)

AND

- Beneficiary is receiving concurrent use of a 5HT3 receptor antagonist

AND

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. Updated September 2019.

3. Antiemetics: American Society of Clinical Oncology Clinical Practice Guideline Update. Journal of Clinical Oncology35, no. 28(October 01, 2017)3240-3261.

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
03/17/2021	Removed post-op nausea and vomiting indication Removed requirement for trial and failure of 5HT3 Added requirement for concurrent use of 5HT3 Specified chemotherapy-induced nausea and vomiting indications as per ASCO guidelines