Antiemetics

Goal(s):
- Promote use of preferred antiemetics.
- Restrict use of costly antiemetic agents for appropriate indications.

Length of Authorization:
- Up to 6 months

Requires PA:
- Non-preferred drugs (oral and topical) will be subject to PA criteria.

Covered Alternatives:
- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What is the diagnosis being treated?	Record ICD10 Code.	
2. Will the prescriber consider a change to the preferred product? Message: • Preferred products do not require a PA. • Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Pharmacy and Therapeutics (P&T) Committee.	**Yes:** Inform prescriber of covered alternatives in class.	**No:** Go to #3
3. Is the request for doxylamine/pyridoxine (Diclegis® or Bonjesta) for pregnancy-related nausea or vomiting?	**Yes:** Go to #4	**No:** Go to #5
4. Has the patient failed a trial of pyridoxine? Message: • Preferred vitamin B products do not require a PA. • Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Pharmacy and Therapeutics (P&T) Committee.	**Yes:** Approve for up to 3 months	**No:** Pass to RPh; deny and recommend a trial of pyridoxine.
5. Is the request for dronabinol (Marinol®)?	**Yes:** Go to #6	**No:** Go to #7
6. Does the patient have anorexia associated with HIV/AIDS?	**Yes:** Approve for up to 6 months.*	**No:** Go to #7
7. Does the patient have a cancer diagnosis AND receiving chemotherapy or radiation?	**Yes:** Approve for up to 6 months.	**No:** Go to #8

8. Does patient have refractory nausea/vomiting that has resulted in hospitalizations or ED visits?	**Yes:** Approve for up to 6 months.*	**No:** Go to #9
9. Has the patient tried and failed, or have contraindications, to at least 2 preferred antiemetics?	**Yes:** Approve for up to 6 months.*	**No:** Pass to RPh. Deny; medical appropriateness. Must trial at least 2 preferred antiemetics
* If the request is for dronabinol (Marinol®) do not exceed 3 doses/day for 2.5 mg and 5 mg strengths and 2 doses/day for the 10 mg strength.		

P&T/DUR Review: *2/21 (KS); 9/17; 1/17; 1/16; 11/14; 9/09; 2/06; 2/04; 11/03; 9/03; 5/03; 2/03*
Implementation: *1/1/18; 4/1/17; 2/12/16; 1/1/15; 1/1/14; 1/1/10; 7/1/06; 3/20/06; 6/30/04; 3/1/04; 6/19/03; 4/1/03*