

Clinical Policy: Dolasetron (Anzemet)

Reference Number: CP.PMN.141

Effective Date: 09.01.06

Last Review Date: 02.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Dolasetron (Anzemet[®]) is a serotonin (5-HT₃) receptor antagonist.

FDA Approved Indication(s)

Anzemet 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.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Anzemet is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Nausea and Vomiting Associated with Cancer Chemotherapy (must meet all):

1. Prescribed for the prevention or treatment of chemotherapy-induced nausea/vomiting;
2. Age \geq 2 years;
3. Member is scheduled to receive cancer chemotherapy (*see Appendix D*);
4. Failure of a formulary 5-HT₃ receptor antagonist (*ondansetron is preferred*) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Request meets one of the following (a or b):*
 - a. Dose does not exceed 100 mg (1 tablet) per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: Projected course of chemotherapy up to 72 hours after completion of chemotherapy

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Nausea and Vomiting Associated with Cancer Chemotherapy (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Member continues to receive cancer chemotherapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed 100 mg (1 tablet) per day;
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: Projected course of chemotherapy up to 72 hours after completion of chemotherapy

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

5-HT₃: serotonin 5-hydroxytryptamine, type 3

ASCO: American Society of Clinical Oncology

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
5-HT₃ Serotonin Antagonists		
Akynzeo® (fosnetupitant/ palonosetron)	Prevention of nausea and vomiting associated with highly emetogenic chemotherapy	1 vial/ chemotherapy cycle

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	1 vial IV given 30 min prior to chemotherapy on day 1	
Akynzeo [®] (netupitant/ palonosetron)	Prevention of nausea and vomiting associated with highly emetogenic chemotherapy 1 capsule PO given 1 hour prior to initiation of chemotherapy on day 1 (in combination with dexamethasone) or 1 vial IV given 30 min prior to initiation of chemotherapy on day 1	1 capsule or vial/chemotherapy cycle
Aloxi [®] (palonosetron)	Prevention of nausea and vomiting associated with chemotherapy 0.25 mg IV given 30 min prior to chemotherapy	0.25 mg/day
granisetron (Kytrel [®])	Prevention of nausea and vomiting associated with chemotherapy Tablet: 2 mg PO QD given 1 hr prior to chemotherapy, or 1 mg PO BID (one dose given 1 hr prior to chemotherapy and then 12 hours later) Injection: 10 mcg/kg IV given within 30 min prior to chemotherapy (on days chemotherapy is given) Treatment of nausea and vomiting associated with chemotherapy* 1 to 2 mg PO daily or 1 mg PO BID or 0.01 mg/kg (maximum 1 mg) IV daily	PO: 2 mg/day IV: 10 mcg/kg/day
ondansetron (Zofran [®] , Zofran [®] ODT, Zuplenz [®])	Prevention of nausea and vomiting associated with moderately emetogenic chemotherapy <u>Age 12 years or older:</u> 8 mg PO given 30 min prior to chemotherapy, then repeat dose 8 hrs after initial dose, then 8 mg PO BID for 1 to 2 days after chemotherapy completion <u>Age 4 to 11 years:</u> 4 mg PO given 30 min prior to chemotherapy, then repeat dose 4 and 8 hrs after initial dose, then 8 mg PO TID for 1 to 2 days after chemotherapy completion Prevention of nausea and vomiting associated with highly emetogenic chemotherapy 24 mg PO given 30 min prior to start of single-day chemotherapy Prevention of nausea and vomiting associated with emetogenic chemotherapy 0.15 mg/kg/dose IV given 30 min prior to chemotherapy, then repeat dose 4 and 8 hrs after initial dose	PO: 24 mg/day IV: 16 mg/dose (up to 3 doses/day)

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Treatment of nausea and vomiting associated with chemotherapy* 16 to 24 mg PO daily or 8 to 16 mg IV	
Sancuso® (granisetron)	Prevention of nausea and vomiting associated with chemotherapy Apply 1 patch at least 24 hrs prior to chemotherapy; may be applied up to 48 hrs after chemotherapy Treatment of nausea and vomiting associated with chemotherapy* Apply 1 patch every 7 days	1 patch/7 days
Sustol® (granisetron)	Prevention of moderately emetogenic chemotherapy or anthracycline/cyclophosphamide chemotherapy 10 mg SC given 30 min prior to chemotherapy on day 1 (in combination with other agents). Do not administer more frequently than once every 7 days.	10 mg/7 days

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

*Off-label

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to the drug
- Boxed warning(s): none reported

Appendix D: American Society of Clinical Oncology (ASCO) and National Comprehensive Cancer Network (NCCN) Recommendations in Oncology

- Minimal emetic risk chemotherapy: No routine prophylaxis is recommended.
- Low emetic risk chemotherapy: Recommended options include dexamethasone (recommended by both ASCO and NCCN) or metoclopramide, prochlorperazine, or a 5-HT₃ receptor antagonist (recommended by NCCN only). NK₁ receptor antagonists are not included in low risk antiemetic recommendations.
- Moderate emetic risk chemotherapy: 5-HT₃ receptor antagonists and dexamethasone may be used in combination and with or without NK₁ receptor antagonists. Olanzapine may also be used in combination with palonosetron and dexamethasone.
 - Examples of moderate emetic risk chemotherapy: azacitidine, alemtuzumab, bendamustine, carboplatin, clofarabine, cyclophosphamide < 1,500 mg/m², cytarabine < 1,000 mg/m², daunorubicin, doxorubicin, epirubicin, idarubicin, ifosfamide, irinotecan, oxaliplatin
- High emetic risk chemotherapy: NK₁ receptor antagonists are recommended for use in combination with 5-HT₃ receptor antagonists and dexamethasone. Olanzapine may also

be used in combination with 5-HT₃ receptor antagonists, dexamethasone, and/or NK₁ receptor antagonists.

- Examples of high emetic risk chemotherapy: carmustine, cisplatin, cyclophosphamide $\geq 1,500$ mg/m², dacarbazine, dactinomycin, mechlorethamine, streptozocin.
- Breakthrough emesis: Per NCCN, an agent from a different drug class is recommended to be added to the current antiemetic regimen. Drug classes include atypical antipsychotics (olanzapine), benzodiazepines (lorazepam), cannabinoids (dronabinol, nabilone), phenothiazines (prochlorperazine, promethazine), 5-HT₃ receptor antagonists (dolasetron, ondansetron, granisetron), steroids (dexamethasone), or (haloperidol, metoclopramide, scopolamine). An NK₁ receptor antagonist may be added to the prophylaxis regimen of the next chemotherapy cycle if not previously included.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Prevention of chemotherapy-induced nausea and vomiting	Adults: 100 mg PO given within 1 hour before chemotherapy	100 mg/day
	Pediatrics (age 2 to 16 years): 1.8 mg/kg PO given within 1 hour before chemotherapy	

VI. Product Availability

Tablets: 50 mg, 100 mg

VII. References

1. Anzemet Prescribing Information. Parsippany, NJ: Validus Pharmaceuticals LLC; June 2016. Available at: <http://anzemet-tablets.com/wp-content/uploads/sites/10/2016/06/anzemet-tablets-pi.pdf>. Accessed October 30, 2019.
2. Hesketh, PJ, Kris MG, Basch E, et al. Antiemetics: American Society of Clinical Oncology Clinical Practice Guideline Update. J Clin Oncol 2017: JCO2017744789.
3. National Comprehensive Cancer Network. Antiemesis Version 1.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/antiemesis.pdf. Accessed October 30, 2019.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: <http://www.clinicalpharmacology-ip.com/>.
5. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed October 30, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2018 annual review: new policy created - policies combined for commercial, HIM, and Medicaid lines of business. For commercial: policy split from CP.CPA.223 Antiemetics – 5-HT ₃ Receptor Antagonist into individual policies, added age requirement, revised trial and failure to remove option of Aloxi and generalize to any 5-HT ₃ antagonist (ondansetron is preferred), generalized	05.15.18	08.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
chemotherapy use (removed specification that member must be receiving highly or moderately emetogenic chemotherapy) due to off-label uses for low emesis risk and breakthrough treatment, added requirement that member is receiving chemotherapy for continuation approval; For HIM: added criteria allowing for off-label use as treatment of chemo-induced N/V, added age requirement, added requirement that member is receiving chemotherapy for initial and continuation approval, generalized trial and failure to any 5-HT ₃ antagonist (ondansetron is preferred), modified approval duration to duration of chemotherapy up to 72 hours after completion of chemotherapy; For Medicaid: policy split from CP.PMN.11 Oral Antiemetics into individual policies, added requirement that member is scheduled to receive or is receiving chemotherapy for initial and continuation approval, removed requirement that ondansetron must have been tried in the last 60 days; modified commercial approval duration to be projected course of chemotherapy up to 72 hrs after completion; references reviewed and updated.		
1Q 2019 annual review: no significant changes; references reviewed and updated.	10.30.18	02.19
1Q 2020 annual review: no significant changes; references reviewed and updated.	11.01.19	02.20

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy; HIM.PA.103.

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