OVERVIEW
This policy documents how certain antiemetic drugs are covered under Part B for BlueCHiP for Medicare members. An antiemetic drug is used to reduce or prevent nausea and vomiting.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
BlueCHiP for Medicare
Oral antiemetics are covered under Part B ONLY under the following circumstances:

- when provided by the facility/physician administering chemotherapy as a full replacement for an intravenous Anti-emetic drug as part of a Cancer Chemotherapeutic regimen. (This includes situations where the patient's dosage will extend beyond the day of chemotherapy (i.e. three drug combination antiemetics)

In all other situations, oral antiemetics are covered under the member's Part D benefit.

Commercial Products
Oral antiemetic drugs are self administered and covered under the pharmacy benefit.

COVERAGE
Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement, for the applicable drug benefits/coverage.

BACKGROUND
An antiemetic drug is most commonly used for nausea associated with chemotherapy or radiotherapy. The medication is typically given before administration of the treatment in order to block the chemicals from activating the brain’s nausea center. Anti-emetics may be taken orally, by injection, or by suppository.

CODING
The following codes are covered for BlueCHiP for Medicare members as a Part B benefit:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J8498</td>
<td>Antiemetic drug, rectal/suppository, not otherwise specified</td>
</tr>
<tr>
<td>J8501</td>
<td>Aprepitant, oral, 5 mg</td>
</tr>
<tr>
<td>J8540</td>
<td>Dexamethasone, oral, 0.25 mg</td>
</tr>
<tr>
<td>J8655</td>
<td>Netupitant 300 mg and palonosetron 0.5 mg</td>
</tr>
<tr>
<td>J8597</td>
<td>Antiemetic drug, oral, not otherwise specified</td>
</tr>
<tr>
<td>J8670</td>
<td>Rolapitant, oral, 1 mg</td>
</tr>
<tr>
<td>Q0161</td>
<td>Chlorpromazine hcl 5mg oral</td>
</tr>
<tr>
<td>Q0162</td>
<td>Ondansetron 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen</td>
</tr>
</tbody>
</table>
Q0163 Diphenhydramine hydrochloride, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen

Q0164 Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0166 Granisetron hydrochloride, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen

Q0167 Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0169 Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0173 Trimethobenzamide hydrochloride, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0174 Thiethylperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0175 Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0177 Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0180 Dolasetron mesylate, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen

Q0181 Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

S0119 Ondansetron, oral, 4 MG (for circumstances falling under the Medicare statute)

RELATED POLICIES
None.

PUBLISHED
Provider Update, June 2017
Provider Update, December 2008

REFERENCES:
None.
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