PHARMACY POLICY STATEMENT
Kentucky Medicaid

DRUG NAME	Varubi (rolapitant)
BILLING CODE	For medical: J8670 For Rx: must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include ondansetron and promethazine QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Varubi (rolapitant) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PREVENTION OF NAUSEA AND VOMITING

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is being used in combination with a serotonin (5-HT3) receptor antagonist **and** dexamethasone in all members receiving highly or moderately emetogenic chemotherapy regimens including carboplatin (AUC ≥ 4)-containing regimens; AND
3. Member has tried and failed to respond to treatment with at least **two** preferred formulary agents for highly or moderately emetogenic chemotherapy (Chart notes or pharmacy claims required).
4. **Dosage allowed:** The recommended dosage for tablet form is 180 mg as a single dose. The recommended dosage for injectable emulsion is 166.5 mg administered as an intravenous infusion over 30 minutes. Medication must be administered prior to the initiation of each chemotherapy cycle, but at **no less than 2 week intervals**.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Varubi (rolapitant) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
01/08/2018	New policy for Varubi created.

References:

1. Varubi [package insert]. Waltham, MA; Tesaro, Inc: October, 2017.
2. Berger MJ, Ettinger DS, Aston J, et al. NCCN Guidelines® Insights. Antiemesis, Version 2.2017. Featured Updates to the NCCN Guidelines. Natl Compr Canc Netw 2017;15(7):883–893. doi:10.6004/jnccn.2017.0117.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Version 2.2017 – March 28, 2017. https://www.nccn.org/professionals/physician_gls/PDF/antiemesis.pdf.

Effective date: 04/04/2018
Revised date: 01/08/2018