Clinical Policy: Tradipitant (Nereus)

Reference Number: CP.PMN.307
Effective Date: 06.01.26
Last Review Date: 05.26
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tradipitant (Nereus™) is substance P/neurokinin-1 (NK-1) receptor antagonist.

FDA Approved Indication(s)

Nereus is indicated for the prevention of vomiting induced by motion in adults.

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 Nereus is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Motion Sickness Prevention (must meet all)**:**

1. Prescribed for the prevention of motion-induced vomiting;
2. Age ≥ 18 years;
3. Member has a planned event expected to cause vomiting induced by motion;
4. Failure of transdermal scopolamine, unless contraindicated or clinically significant adverse effects are experienced;*
   * *For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Failure of ≥ 2 antihistamines used for motion sickness (e.g., dimenhydrinate, meclizine, promethazine), unless clinically significant adverse effects are experienced or all are contraindicated;*
   * *For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Request is for ≤ 7 days supply, unless medical justification is provided;
7. Request is for ≤ 90 doses per 365-day period, unless medical justification is provided;
8. Dose does not exceed 170 mg (2 capsules) per 24-hour period.

Approval duration: 7 days

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Motion Sickness Prevention

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NK-1: neurokinin-1

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
scopolamine (Transderm-Scop®)	Apply one transdermal system behind one ear at least 4 hours before antiemetic effect is required for use up to 3 days	1 patch (1 mg) every 3 days
dimenhydrinate (Dramamine®)	50 to 100 mg PO every 4 to 6 hours as needed	400 mg/day
meclizine (Antivert®, Bonine®)	25 to 50 mg PO 1 hour before travel. May repeat dose every 24 hours as needed	50 mg/day
promethazine (Phenergan®)	25 mg PO 30 to 60 minutes before departure, then every 12 hours as needed.	50 mg/day

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.

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Motion sickness prevention	85 mg or 170 mg as a single oral dose approximately 60 minutes before an event expected to cause vomiting induced by motion	170 mg/24-hour period

VI. Product Availability

Capsule: 85 mg

VII. References

1. Nereus Prescribing Information. Washington, DC: Vanda Pharmaceuticals; December 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220152Orig1s000lbl.pdf. Accessed January 22, 2026.
2. Polymeropoulos VM, Kiely L, Bushman ML, et al. Motion Syros: tradipitant effective in the treatment of motion sickness; a multicenter, randomized, double-blind, placebo-controlled study. Front Neurol. 2025 Mar 4;16:1550670. doi: 10.3389/fneur.2025.1550670. eCollection 2025
3. CDC. Motion Sickness. In: CDC Yellow Book: Health Information for International Travel. Golding JF. Page last reviewed: April 23, 2025. Available at: https://www.cdc.gov/yellow-book/hcp/travel-air-sea/motion-sickness.html. Accessed January 26, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.24.26	05.26

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.

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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.

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