Clinical Policy: Oral Bisphosphonates
Reference Number: CP.PMN.43
Effective Date: 09/06
Last Review Date: 02/17
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description
Risedronate (Actonel®, Atelvia®), ibandronate (Boniva®), etidronate (Didronel®), and tiludronate (Skelid®) are oral bisphosphonates requiring prior authorization.

FDA approved indication
Actonel is indicated for:
- Treatment and prevention of postmenopausal osteoporosis
- Treatment to increase bone mass in men with osteoporosis
- Treatment and prevention of glucocorticoid induced osteoporosis
- Treatment of Paget's disease
  Limitation of use: Optimal duration of use has not been determined. For patients at low-risk for fracture, consider during discontinuation after 3 to 5 years of use.

Boniva is indicated for:
- Treatment and prevention of postmenopausal osteoporosis

Didronel is indicated for:
- Treatment of Paget's Disease
- Prevention and treatment of heterotopic ossification following total hip replacement or due to spinal cord injury

Skelid is indicated for:
- Treatment of Paget's Disease

Atelvia is indicated for:
- Treatment of postmenopausal osteoporosis
  Limitation of use: Optimal duration of use has not been determined. For patients at low-risk for fracture, consider during discontinuation after 3 to 5 years of use.

Policy/Criteria
** Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria **

It is the policy of health plans affiliated with Centene Corporation® that non-preferred oral bisphosphonates are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Osteoporosis/Osteoporosis Prophylaxis (must meet all)**:**

1. Request is for treatment or prophylaxis of osteoporosis;
2. Member meets one of the following (a or b):
   a. Failure of alendronate as evidenced by a documented history of fracture while on therapy;

b. Failure of ≥ 12 month trial of alendronate at maximum indicated doses as evidenced by a lack of improvement in baseline bone mineral density, unless member experiences clinically significant adverse effects or has contraindication(s) to alendronate;

3. Request is for Actonel, Atelvia, or Boniva.

Approval duration: 12 months

B. Paget's Disease (must meet all)**:**

1. Diagnosis of Paget's disease;
2. Failure of ≥ 6 month trial of alendronate at maximum indicated doses as evidenced by inability to achieve normal serum alkaline phosphate levels, unless member experiences clinically significant adverse effects or has contraindication(s) to alendronate;
3. Request is for Didronel, Skelid, or Actonel.

Approval duration: Didronel and Skelid - 3 months; Actonel: 2 months

C. Heterotopic Ossification (must meet all):

1. Diagnosis of heterotopic ossification resulting from spinal cord injury or following total hip arthroplasty;
2. Request is for Didronel.

Approval duration: Total hip arthroplasty- 4 months; Spinal cord injury - 3 months

D. Hypercalcemia Associated with Malignant Neoplasms (must meet all):

1. Diagnosis of hypercalcemia associated with malignancy;
2. Request is for Didronel.

Approval duration: 30 days

E. Other diagnoses/indications – Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

II. Continued Therapy

A. Osteoporosis/Osteoporosis Prophylaxis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Responding positively to therapy.

Approval duration: 12 months

B. Paget's Disease

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has had a medication-free period of 90 days if on Didronel/Skelid and 60 days for Actonel.

Approval duration: Didronel and Skelid - 3 months; Actonel: 2 months

C. Heterotopic Ossification

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has NOT received ≥ 3 months of treatment for heterotopic ossification from spinal cord injury or ≥ 4 months treatment following total hip arthroplasty;
3. Responding positively to therapy.

Approval duration:
Allow for no more than 4 months of treatment TOTAL for total hip arthroplasty
Allow for no more than 3 months of treatment TOTAL for spinal cord injury

D. Hypercalcemia Associated with Malignant Neoplasms

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria.
2. Responding positively to therapy;

Approval duration: Up to an additional 60 days (maximum total therapy of 90 days)

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PMN.53 if requested indication is NOT listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

Approval duration: 6 months

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 policy - CP.PMN.53 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation Key
Not applicable

V. Dosage and Administration

Drug	Recommended Dose	Maximum Dose
Actonel (risedronate)	Treatment of postmenopausal osteoporosis: 5 mg daily, 35 mg once-a-week, 75 mg two consecutive days each month, 150 mg once-a-month Prevention of postmenopausal osteoporosis: 5 mg daily, 35 mg once-a-week Men with osteoporosis: 35 mg once-a-week Glucocorticoid-induced osteoporosis: 5 mg daily Paget's Disease: 30 mg daily for 2 months	Osteoporosis: 5 mg/day, 35 mg/week (either immediate-release or delayed-release tablets), or 150 mg/month Paget's disease: 30 mg/day

Fosamax (alendronate)	Treatment of osteoporosis in postmenopausal women and in men: 10 mg daily or 70 mg (tablet or oral solution) once weekly. Prevention of osteoporosis in postmenopausal women: 5 mg daily or 35 mg once weekly. Glucocorticoid-induced osteoporosis: 5 mg daily; or 10 mg daily in postmenopausal women not receiving estrogen. Paget's disease: 40 mg daily for six months	Osteoporosis: 10 mg/day PO or 70 mg/week Paget's disease: 40 mg/day
Boniva (ibandronate)	Take one 150 mg tablet once monthly on the same day each month	2.5 mg/day or 150 mg/month
Didronel (etidronate)	Paget's disease: 5 to 10 mg/kg/day, not to exceed 6 months or 11 to 20 mg/kg/day, not to exceed 3 months Heterotopic ossification: Total Hip Replacement Patients: 20 mg/kg/day for 1 month before and 3 months after surgery (4 months total) Spinal Cord Injured Patients: 20 mg/kg/day for 2 weeks followed by 10 mg/kg/day for 10 weeks (12 weeks total)	20 mg/kg/day
Skelid (tiludronate)	400 mg daily for 3 months	400 mg/day
Atelvia (risedronate)	35 mg once a week	35 mg/week

VI. Product Availability

Drug	Availability
Actonel (risedronate)	5 mg, 30 mg, 35 mg, 75 mg, and 150 mg tablets
Fosamax (alendronate)	70 mg tablet
Boniva (ibandronate)	150 mg tablet
Didronel (etidronate)	200 mg, 400mg tablet
Skelid (tiludronate)	200 mg tablet
Atelvia (risedronate)	35 mg delayed-release tablet

VII. Workflow Document

Oral Bisphosphonates W

VIII. References

1. Actonel Prescribing Information. Rockaway, NJ: Warner Chilcot, LLC. April 2015. Available at http://www.allergan.com/. Accessed December 2016.
2. Fosamax Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc., August 2015. Available at https://dailymed.nlm.nih.gov. Accessed December 2016.
3. Boniva Prescribing Information. South San Francisco, CA: Genetech USA, Inc. October 2015. Available at https://www.gene.com/. Accessed December 2016.
4. Didronel Prescribing Information. Morgantown, WV: Mylan Pharmaceuticals Inc. April 2015. Available at https://dailymed.nlm.nih.gov/. Accessed December 2016.
5. Skelid Prescribing Information. Bridgewater, NJ: Sanofi-Aventis US, LLC. March 2010. Available at http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/020707s006lbl.pdf. Accessed December 2016.
6. Atelvia Prescribing Information. North Norwich, NY: Norwich Pharmaceuticals, Inc. March 2015.Available at http://www.allergan.com. Accessed December 2016.
7. Camacho PM, Petak SM, Brinkley N et al. AACE/ACE Guidelines- American Association of Clinical Endocrinologists and American College of Endocrinology Clinical Practice Guidelines for Diagnosis and Treatment of Postmenopausal Osteoporosis. Endocrine Practice Vol 22 (suppl 4) September 2016.

Reviews, Revisions, and Approvals	Date	Approval Date
References updated.	11/12	11/12
Removed the medical necessity statement under description and Replaced it with a proper description of the bisphosphonate drug class.	11/13	11/13
Removed Actonel from the listed pdl brands and moved it to nonpdl section since it is a non-PDL medication and re-arranged the writing of available brands so that the generic name is listed first with brand name in parenthesis to make this consistent throughout the document. Added Fosamax plus D (Alendronate) to available non-PDL. Clarified that indication 3 & 4 under FDA labeled indication apply etidronate only. Under approval criteria for osteoporosis/Paget's disease: added the requirement for concurrent use of calcium and vitamin D (see reference #7 and clinical pharmacology references) and required "adherent" use of alendronate. Under criteria: defined failure of therapy for both osteoporosis and Paget's disease. Under approval section added Atelvia for approval for osteoporosis. Updated references and added new references to support recommendations.		
Updated References. Changed specific drugs in guideline to reflect preferred and non-preferred status.	12/14	12/14
Added osteoporosis continued approval criteria. Updated references.	4/15	4/15
Converted to new policy template; Specified the preferred medication for osteoporosis/paget's disease; Removed requirement for concurrent use of calcium and vitamin D for the osteoporosis criteria; Clarified the approval	12/15	02/16

Reviews, Revisions, and Approvals	Date	Approval Date
criteria and renewal criteria for each agent/disease state; Added dosage limitation based on FDA recommended limit; Referenced updated		
Converted to new integrated template; Removed age limits; added positive response to therapy requirement for re-authorization; updated references.	12/16	02/17

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.

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.