

Pharmacy Medical Necessity Guidelines: OspheTM (ospemifene)

Effective: January 12, 2021

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
<p>These pharmacy medical necessity guidelines apply to the following:</p> <p>Commercial Products</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tufts Health Plan Commercial products – large group plans <input type="checkbox"/> Tufts Health Plan Commercial products – small group and individual plans <input type="checkbox"/> Tufts Health Freedom Plan products – large group plans <input type="checkbox"/> Tufts Health Freedom Plan products – small group plans • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>Tufts Health Public Plans Products</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product) <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan 		<p>Fax Numbers: RXUM: 617.673.0988</p>	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

OspheTM is indicated for:

- The treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy, due to menopause, and
- The treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy, due to menopause

COVERAGE GUIDELINES

The plan may authorize coverage of OspheTM (ospemifene) for Members when the following criterion is met:

1. The Member tried and failed therapy with two alternative products, or the provider indicates clinical inappropriateness of treatment with at least two alternative products, such as oral estrogen therapy and topical estrogen therapy

LIMITATIONS

None

CODES

None

REFERENCES

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9. Portman DJ, Bachmann GA, Simon JA, et al. Ospemifene, a novel selective estrogen receptor modulator for treating dyspareunia associated with postmenopausal vulvar and vaginal atrophy. *Menopause*. 2013; 20(6).
10. Premarin vaginal cream prescribing information. Philadelphia, PA: Pfizer Inc.; 2012 May.
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16. The North American Menopause Society. Management of symptomatic vulvovaginal atrophy: 2013 position statement of The North American Menopause Society. *Menopause*. 2013;20:888-902.

APPROVAL HISTORY

June 12, 2014: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. January 12, 2016: No changes.
2. January 10, 2017: Removed raloxifene as a step therapy option.
3. May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template
4. June 12, 2018: No changes.
5. March 12, 2019: Administrative changes made to template.
6. January 14, 2020: No changes.
7. January 12, 2021: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

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