Pharmacy Medical Necessity Guidelines: Bisphosphonate Medications (alendronate w/ vitamin D, ibandronate, risedronate)

Effective: August 13, 2019

Prior Authorization Required: √
Type of Review – Care Management
Not Covered
Type of Review – Clinical Review: √

Pharmacy (RX) or Medical (MED) Benefit
PO: RX/IV: MED
Department to Review: RXUM/MM

Fax Numbers:
RXUM: 617.673.0988
MM: 888.415.9055

These pharmacy medical necessity guidelines apply to the following:

**Commercial Products**
- Tufts Health Plan Commercial products – large group plans
- Tufts Health Plan Commercial products – small group and individual plans
- Tufts Health Freedom Plan products – large group plans
- Tufts Health Freedom Plan products – small group plans
  - CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Tufts Health Public Plans Products**
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health RITogether – A Rhode Island Medicaid Plan

**OVERVIEW**

**FDA-APPROVED INDICATIONS**

Oral bisphosphonates are indicated for:
- Treatment of postmenopausal osteoporosis (OP) (alendronate, ibandronate, risedronate);
- Prevention of postmenopausal osteoporosis (alendronate, ibandronate, risedronate);
- Treatment of osteoporosis in males (alendronate, risedronate);
- Treatment of Paget’s disease of the bone (alendronate, risedronate);
- Treatment and prevention of glucocorticoid-induced osteoporosis (alendronate, risedronate)

Please refer to the Zoledronic Acid Medical Necessity Guideline for requests for zoledronic acid products.

**COVERAGE GUIDELINES**

The plan may authorize coverage of a non-preferred bisphosphonate product for Members when one of the following criterions is met and limitations do not apply:

1. The request is for Paget’s disease, hypercalcemia of malignancy, bone metastases, osteolytic/bone disease, or potential skeletal-related events secondary to a diagnosis of cancer or associated with cancer treatments

2. The Member tried and failed therapy with alendronate, or there is clinical justification to avoid therapy with alendronate

**LIMITATIONS**

1. Combination products require the Member to utilize the bisphosphonate and the dietary supplement, such as vitamin D or calcium, separately.
2. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Non-covered Medications criteria.
3. Quantity limits apply as follows:

<table>
<thead>
<tr>
<th>Generic name</th>
<th>Strength (mg)</th>
<th>Treatment and prevention of post-menopausal OP</th>
<th>Male OP</th>
<th>Glucocorticoid-induced OP</th>
<th>Paget’s disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alendronate</td>
<td>5</td>
<td>#30</td>
<td>#30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommended Monthly Dosing**

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).
<table>
<thead>
<tr>
<th>Generic name</th>
<th>Strength (mg)</th>
<th>Treatment and prevention of post-menopausal OP</th>
<th>Male OP</th>
<th>Glucocorticoid-induced OP</th>
<th>Paget’s disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Recommended Monthly Dosing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>#30 (prevention in women without estrogen replacement)</td>
<td>#30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>#4 (prevention)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40</td>
<td></td>
<td></td>
<td>#30/mon x 6 mon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70</td>
<td>#4 (treatment)</td>
<td></td>
<td>#4</td>
<td></td>
</tr>
<tr>
<td>Ibandronate</td>
<td>2.5</td>
<td>#30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>150</td>
<td>#1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3/3ml</td>
<td>#3ml q 3mon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>#30</td>
<td></td>
<td>#30/mon x 2 mon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risedronate</td>
<td>35 (IR)</td>
<td>#4</td>
<td></td>
<td>#4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>35 (DR)</td>
<td>#4 (treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>75</td>
<td>#2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>150</td>
<td>#1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CODES**

None

**REFERENCES**

2. Fosamax® (alendronate) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; December 2015.
5. Actonel® (risedronate sodium) [prescribing information]. Bridgewater, NJ: Sanofi-Aventis; April 2015.

**APPROVAL HISTORY**

July 17, 2008: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. October 14, 2014: No changes
2. September 16, 2015: No changes
3. January 1, 2016: Administrative change to rebranded template.
4. September 13, 2016: Removed Skelid® from the policy due to product discontinuation.
5. May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template
8. August 13, 2019: 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.