



PHARMACY MEDICAL POLICY

Policy #: 058

Posted: 9/1/09

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Title

Bisphosphonate, Oral

Actonel[®] (risendronate)

Boniva[®] (ibandronate)

Fosamax[®] (alendronate), oral solution

Fosamax[®] (alendronate), tablets

Prescription Drug Step Therapy

Note: All requests for **outpatient retail pharmacy** for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the **Prior Authorization Form** on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients at (800)366-7778. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

For Medicare Advantage members, please refer to Medical Policy #[109](#)

Quality Care Dosing guidelines apply to the following medications and can be found in Medical Policy #[621](#).

| Standard Formulary | |
|--|---|
| Drug | Formulary Status |
| STEP 1 | |
| <ul style="list-style-type: none"> alendronate Fosamax[®] oral solution | Covered |
| STEP 2 | |
| <ul style="list-style-type: none"> Actonel[®] Actonel[®] and Calcium | Prior use of Step 1 Required |
| STEP 3 | |
| <ul style="list-style-type: none"> Boniva^{®*} Fosamax[®] tablets Fosamax[®] Plus D | Prior use of Step 1 and Step 2 required |

| Blue Value Rx Formulary | |
|--|-------------------------|
| Drug | Formulary Status |
| STEP 1 | |
| <ul style="list-style-type: none"> alendronate Fosamax[®] oral solution | Covered |

| | |
|------------------------------------|---|
| STEP 2 | |
| • Actonel [®] | Prior use of Step 1 Required |
| • Actonel [®] and Calcium | |
| STEP 3 | |
| • Boniva ^{®*} | Prior use of Step 1 and Step 2 required |
| • Fosamax [®] tablets | |
| • Fosamax [®] Plus D | |

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

When services are covered

We cover the oral bisphosphonate medications listed in the chart above for new starts* in the following stepped approach¹

*New start is defined as no previous paid claim for the requested medication within the past 130 days.

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications will be covered when **one** of the following criteria is met:

- There must be evidence of a BCBSMA paid claim or physician documented use** by the patient of a step 1 drug within the previous 130 days

OR

- There must be evidence of a BCBSMA paid claim by the patient of a step 2 drug within the previous 130 days

Step 3: Step 3 medications will be covered when **one** of the following criteria is met:

- There must be evidence of a BCBSMA paid claim or physician documented use** by the patient of a step 1 drug and step 2 drug within the previous 130 days

OR

- There must be evidence of a BCBSMA paid claim by the patient of a step 3 drug within the previous 130 days

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

When services are not covered

We do not cover drugs listed in the above chart when the above step therapy criteria are not met.

Individual consideration

All our policies are written for the majority of people with given conditions. For many of our policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Prescribers may send relevant clinical information for individual patients for coverage consideration to:

Blue Cross Blue Shield of Massachusetts
Clinical Pharmacy Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Managed care, PPO and Indemnity guidelines

Prior Authorization is required for all plans as these drugs are processed as a Pharmacy benefit.

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients:
Pharmacy Operations: (800)366-7778
- Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for prior authorization.

Coding information

Physician billing is not applicable as these medications are billed through the pharmacy benefit.

Policy update history

Medical policy developed and effective 09/01/2008. Policy updated 09/09 to change 180 day look back period to 130 days and to remove Medicare Part D criteria from Medical Policy.

Scientific background, Rationale and References

¹Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 5/13/08.

References:

1. Actonel[®] [package insert]. Cincinnati, OH: Procter & Gamble Pharmaceuticals; 2008.
2. Boniva[®] [package insert]. Nutley, NJ: Roche Pharmaceuticals; 2006.
3. Fosamax[®] [package insert]. Whitehouse Station, NJ: Merck & Co.; 2008.

This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Request for Outpatient Retail Pharmacy Prior Authorization

Fax to: Clinical Pharmacy Program (800) 583-6289

Phone Authorization (800)366-7778

We plan to respond to your request within two business days of our receipt. To ensure that we can confirm your request (required by NCQA), please be sure to include your fax number.

| | |
|---|---|
| We cannot process requests unless they contain all of the information requested below: | |
| Patient Information (REQUIRED) | |
| Name | |
| BCBSMA ID number | |
| Is the patient a BCBSMA employee? If yes, please fax request to: (617) 246-4013 | Yes No |
| Date of Birth | |
| Patient's Diagnosis or ICD-9-CM code | |
| Physician Information (REQUIRED) | |
| Name | |
| Medical Specialty/NPI # | |
| BCBSMA Provider number | |
| Telephone Number | |
| Fax Number | |
| Contact Name (if different from physician) | |
| Please select one of the three following sections to complete, depending on the nature of your request for the above-named patient. | |
| Formulary Exception Request | |
| Name of non-covered drug you want to prescribe | |
| Reason for Individual Consideration Request (please check one): <input type="checkbox"/> Treatment failure with the following covered drugs in class <input type="checkbox"/> Documented adverse reaction to the following covered drugs <input type="checkbox"/> Other clinical reason (please specify) _____ | |
| Quality Care Dosing Override Request | |
| Drug name, strength and quantity requested: | |
| Clinical reason for override (please specify) | |
| Outpatient Retail Pharmacy Prior Authorization Request | |
| Drug name: | |
| Start/End date (must be one year or less): | |
| Associated Co-morbid diagnosis: | |
| For Epogen®/Procrit® only: | GFR: |
| | Is patient certified ESRD with Medicare? Yes No |
| MD Signature: | Date: |